

IN THE UNITED STATES DISTRICT
COURT WESTERN DIVISION FOR THE
NORTHERN DISTRICT OF OHIO

Renz, et. al,
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&

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-VS-

State of Ohio, et. al

Defendant(s)

CASE NO. 3:20-cv-1948

JUDGE: Honorable Judge
James Carr

EXHIBIT – Attachments C: COVID-19 Testing

The following has been submitted by Plaintiff's attorney, Thomas Renz.

Respectfully submitted,

s/ Thomas Renz

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Inflated Cases and Deaths

As you've learned, the number of cases and deaths did not warrant the declaration of a pandemic and certainly did not warrant drastic interventions in the U.S. such as shelter-in-place, closure of most businesses, sending children home from school, and loss of personal freedoms. But even the low numbers were almost certainly inflated.

Inaccurate Testing

From the beginning, COVID-19 testing in the U.S. has been flawed. While the World Health Organization had developed testing specifications for COVID-19 by January 2020, the CDC decided to develop its own test, which was ready by early February. The test was manufactured and distributed by the CDC to health centers throughout the U.S., and within a few days, the tests were found to be inaccurate. In response the FDA insisted that hospitals, academic centers and private companies ***should not develop their own tests***. When the agency finally lifted the ban on test development at the end of February, there was a rush to get tests ready for market. Although the FDA provided no standards for how COVID-19 was to be detected. This meant all test makers could decide what standard to use.

Over 100 companies are currently producing tests for COVID-19, and these tests were approved by the FDA under emergency authorization with minimal validation. The test makers only had to show that the tests performed well in test tubes and no real-world demonstration of clinical viability was required.¹ Each vendor established its own and as-yet-unmeasured accuracy. The variations are myriad, with some tests able to detect as few as 100 copies of a viral gene while others require 400 copies for detection.² Additionally, most will show positive results for as long as 6 months, while the actual time a person is contagious is only a few days.

Several issues were never addressed. One is the potential cross-reactivity with other viruses. Another is that the presence of coronavirus is likely to remain for several months after the infectious period has passed. This means the tests are useless for determining who should be quarantined. Yet another is the risk of cross contamination, particularly when testing large numbers of people in crowded settings. Even the tiniest amount of cross contamination can lead to a false positive result, which means people who have never been exposed to COVID-19 could be subjected to unwarranted quarantines.

The accuracy of tests is important since numbers of "cases" is the metric used to determine business closures, event cancellations, lockdowns, withdrawal of civil rights and liberties, whether people can congregate, and if the useless masks are required.

There are two primary processes used to test for the coronavirus. The first method requires a sample of mucus from a person's nose or throat and then attempting to

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replicate the RNA through a Polymerase Chain Reaction (PCR) machine. The second is through the antibody test, a blood test that is supposed to determine not if one is infected, but if they have ever been infected. Both tests are flawed.

Biochemist Kary Mullis is the inventor of the PCR test and won the Nobel Prize in chemistry for his invention in 1993. Mullis stated in 2013 that PCR was never designed to diagnose disease. The test finds very small segments of a nucleic acid which are components of a virus. According to Mullis, having an actual infection is quite different than testing positive with PCR. According to Mullis, PCR is best used in medical laboratories and for research purposes.

Dr. David Rasnick, also a biochemist and founder of a lab called Viral Forensics, agrees. "You have to have a whopping amount of any organism to cause symptoms. Huge amounts of it. You don't start with testing; you start with listening to the lungs. I'm skeptical that a PRC test is ever true. It's a great scientific research tool. It's a horrible tool for clinical medicine. 30% of your infected cells have been killed before you show symptoms. By the time you show symptoms...the dead cells are generating the symptoms."

When asked about having a COVID-19 test he stated, "Don't do it, I say, when people ask me. No healthy person should be tested. It means nothing but it can destroy your life, make you absolutely miserable." He went on to say, "Every time somebody takes a swab, a tissue sample of their DNA, it goes into a government database. It's to track us. They're not just looking for the virus. Please put that in your article."³

In fact, PCR testing was already shown to be wildly inaccurate almost 15 years ago. In 2006, massive PCR testing was performed at the Dartmouth Hitchcock Medical Center when it was thought that the medical center was experiencing an epidemic of whooping cough. Almost 1000 healthcare workers were furloughed until their test results were returned. Over 140 employees were told that they had whooping cough, and thousands of others who tested positive were given antibiotics and/or a vaccine for whooping cough.

Almost eight months later, employees received an email from the hospital administration which stated that the entire episode was due to PCR testing error. Not even one case of whooping cough was confirmed with a more reliable follow-up test, and it was determined that the employees just had a common cold, not whooping cough.⁴

Apparently, this history was ignored as incompetent health officials like Mr. Fauci decided that ginning up cases was more important than following the science. Thus, a test that the developer said was not useful for diagnosis and that had been previously shown to be inaccurate 100% of the time was recommended for COVID-19.

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A recent meta-analysis published in the *British Medical Journal* looked at the accuracy of PCR testing specifically for COVID-19. The researchers reported that while no test is 100% accurate, the sensitivity and specificity of a test is evaluated by comparison with a gold standard, and there is no gold standard for COVID-19. One of the reasons is that it is impossible to know the false positive rate without having tested people who don't have the virus along with people who do, and this was never done.

The analysis showed that the false negative rate ranges between 2% and 29%. Accuracy of viral RNA swabs was highly variable. In one study, sensitivity was 93% for bronchoalveolar lavage, 72% for sputum, 63% for nasal swab, and only 32% for throat swabs. The researchers stated that results vary for many reasons including stage of disease.⁵ This analysis was published in May, long after Mr. Fauci and his accomplices had succeeded in creating a false pandemic, in part by insisting that more and more people should be tested.

Fortunately, many people are far more diligent than Fauci in checking out facts. Investigators from *OffGuardian* contacted the authors of four papers published in early 2020 in which researchers claimed that they had discovered a new coronavirus. The investigators asked for proof that electron micrographs showed purified virus and all four groups replied that they did not.

Here are the verbatim responses from the four groups:

"The image is the virus budding from an infected cell. It is not purified virus."

"We could not estimate the degree of purification because we do not purify and concentrate the virus cultured in cells."

"[We show] an image of sedimented virus particles, not purified ones."

"We did not obtain an electron micrograph showing the degree of purification."

The investigators also contacted virologist Charles Calisher and asked if he knew of any research group that had isolated and purified SARS-COV-2 and he replied that he did not. They concluded at this time no one knows whether the RNA gene sequences used in the in vitro trials and which were used to calibrate the tests came from SARS-CoV-2.⁶

All of this may explain why some of the testing results from around the world have been so difficult to understand or explain. For example, testing in Guangdong province in China showed that 10% of people who recovered from COVID-19 tested negative and then tested positive again.⁷ Twenty-nine patients tested in Wuhan tested negative, then positive, and then the results were "dubious."⁸

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According to Wang Chen, president of the Chinese Academy of Medical Sciences, PCR tests are only 30-50% accurate.⁹

The CDC agrees. A statement in its online instruction manual for PCR testing includes these statements:

Detection of viral RNA may not indicate the presence of infectious virus or that 2019-nCoV is the causative agent for clinical symptoms.”

This test cannot rule out diseases caused by other bacterial or viral pathogens.”¹⁰

The FDA’s online emergency use authorization includes this statement:

“positive results [...] do not rule out bacterial infection or co-infection with other viruses. The agent detected may not be the definite cause of disease.”¹¹

In fact, the manufacturer’s instruction manual for one PCR test includes these statements:

These assays are not intended for use as an aid in the diagnosis of coronavirus infection”

For research use only. Not for use in diagnostic procedures.”¹²

The bottom line is that this test is useless for diagnosing COVID-19. If the error rate is only 5% this could mean that the number of cases worldwide is off by millions. But the error rate is most likely much higher, which means that the world’s population is suffering due to a made-up pandemic.

There Are Other Serious Issues

Some county and state health departments state that the counts for coronavirus are typically reported via a primary care physician or pulmonologist.¹³ Most likely neither of these provider types has an expensive PCR machine at their disposal. Thus, it would appear as though the virus is being diagnosed by physicians the same way they would diagnose any common cold or flu, which is by physical examination and observation of symptoms. The symptoms of COVID-19 are like those of influenza in many ways.

Several Governors in the U.S. requested billions of dollars in federal aid to “assist with the impact of the coronavirus,” the amount of which was based on the infection rate. Collectively, they requested a total of \$500 billion.¹⁴ At this time there is no accountability for exactly how this aid was spent. It is interesting that the states with the worst per capita debt (such as California and New York) have requested the most money.¹⁵ Coincidence? Perhaps not. Naturally, it could make sense to report a higher rate of infection in order to receive a larger piece of the stimulus.

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There have been numerous problems with the testing procedures, some political, some scientific. The CDC went against the guidance of the World Health Organization (WHO).¹⁶ The irony, of course, is one corrupt organization ignoring the guidelines of another corrupt organization. Ultimately, the missteps that occurred regarding testing were massive. On April 20, 2020, it was reported that the tests the CDC was using were contaminated with the coronavirus itself.¹⁷ There was no way to know the number of false negatives and false positives.

The Food and Drug Administration (FDA) sent representatives to the CDC and found the primary culprit to be poor laboratory practices. The CDC offered no defense for its decisions.

Testing was not much better in other parts of the world. For example, Spain and the Czech Republic spent millions on a test purchased from a Chinese company called "Shenzhen Bioeasy Technology" and later found that the tests were only 30% accurate. Gordon Chang, who has covered Chinese economics and policy for decades stated "It [China] creates the poison and then sells the cure to it."¹⁸ How purposeful was this? We will never know, although China had an incentive to keep the world frightened and shut down, both to gain economic advantage and to distract the world while it engaged in practices condemned by many countries.

Even if the test kits are not faulty, more false negatives can result from the swabbing method used to collect samples. The tests typically require a swab to be inserted into the nasal passage. This is a common method used in the "drive-thru" testing sites set up in many cities. In order to be properly detected, the swab must be inserted deep into the nasal passage, causing considerable discomfort. Many of those performing the tests were either not properly trained or tended to withdraw the swab early when the patient exhibited discomfort or resistance.

Dr. Michael Pintella, Director of the State Hygienic Lab in Iowa, stated "Tests involve a multi-step process and each step might lead to a false negative result for any number of reasons, including a poorly collected specimen, a delay in transport of the specimen to the lab, not storing or transporting specimens at the appropriate temperature, problems encountered during testing extraction, analysis errors and more."¹⁹ In the same news release Dr. Austin Baeth, who was very outspoken about wanting to administer a state lockdown for Iowa, admitted that the tests only have a 63% accuracy rate.

The other common method for testing is the antibody test, which uses a blood sample. The problem with this test is that it does not determine if one has the virus, rather if one has had it before. This is also problematic, as there are many false positives due to detecting antibodies created from other coronaviruses (such as the common cold).²⁰ The methodology is flawed as well. According to a report released in early May, the FDA had to tighten restrictions on the hundreds of companies that were profiting from

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selling fraudulent testing kits.²¹ Some of these kits were even being advertised as “do it yourself from home” products. It is widely believed that there are many false negatives arising from these kits as well.

To make matters worse, the CDC had been reporting positive test results from a combination of both the PCR test and the antibody test. Ashish Jha, the K.T. Li Professor of Global Health at Harvard University said, “You’ve got to be kidding me. How could the CDC make that mistake? This is a mess.”²² He further went on to say that mixing the results of the two tests muddies the water. One test is like looking in the rearview mirror and the other just says if one is infected now. He also stated that because of this, the actual amount of cases is and was much higher than reported.

Testing in Tanzania: Apparently Fruit Can Test Positive

The head of Tanzania’s health laboratory in charge of coronavirus was suspended after President John Magufuli of Tanzania had a security detail obtain random samples of Pawpaw, jackfruit, and animals which tested positive for COVID-19.

Samples of fruit were taken from inside the fruit – therefore positive results could not be from someone touching the fruit. The samples were given names and sent to the laboratory.

Here were the results:

Sample of car oil named Jabil Hamza, 30 years old, male - negative

Sample from Jackfruit named Sarah Samuel 45 years old, female - inconclusive test results

Sample of liquid from Pawpaw named Elizabeth Anne 26 years old female - positive

Samples from Kware (type of bird) – positive

Samples from rabbit – undetermined

Goat – positive

Sheep – negative

Magufuli said that this means the Pawpaw named Elizabeth must be placed in isolation, goats should be in isolation, and Jackfruit named Sara should be in isolation. But, he reported, the Pawpaw is not dying it’s just getting ripe. Magufuli says, “a dirty game is being played with these tests,” reported that the tests were imported, and said the WHO should do something about this. He told Reuters that this indicates that some people are testing positive who not have the disease.

The Centers for Disease Control and Prevention says there is no way that fruit can contract COVID-19

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As of May 6, 2020, there were 480 cases and 17 deaths in Tanzania, and there was no way to know if the goats, sheep, bird, Pawpaw and jackfruit were included in the count.^{23 24}

But You Must Have COVID-19! You Must!

NBC referred to Dr. Joseph Fair as "...Today's most knowledgeable expert on the coronavirus outbreak." Dr. Fair reported that he was recently diagnosed with COVID-19, and tweeted that he was hospitalized with it.

According to Dr. Fair, he flew home from New York City to New Orleans wearing a mask and gloves, wiped everything down but says he must have contracted it through his eyes. He said that his symptoms were not classic symptoms, but when he developed shortness of breath, he called an ambulance and was admitted to Tulane Medical Center. He had four COVID tests and they were all negative, but he knows he had it and his doctors confirmed that this was the case.

It seems that anyone determined to have COVID-19 will have it – testing does not matter. Apparently, nor does wearing masks and gloves and wiping things down.²⁵

And If All Else Fails, Use "Medical Intuition"

An article in Medscape posted May 16, 2020 describes a patient who arrived at UC San Diego Health medical center with classic COVID-19 symptoms – a history of cough, pneumonia, severe respiratory distress – and required immediate intubation. The patient's back of the throat was swabbed twice and both times was negative for COVID-19. "The two negative tests didn't convince anybody," said Davey Smith, MD, a virologist and chief of the division of infectious diseases and global public health at UC San Diego School of Medicine. It was only on the third test, when they sampled fluid from a bronchial wash, that they were able to find the virus.²⁶ The article was titled "Don't Discount Medical Intuition."

The article went on to say that this is not an isolated incident because there are limitations to current tests and that clinicians report false negative rates as high as 30%. The FDA issued an alert warning of false negatives with Abbott Labs' ID NOW rapid test, one of the most used.²⁷

The authors also cited data in *Annals of Internal Medicine* showing that test accuracy depends on when the person is tested because the false negative results vary during the course of the disease. According to this study, on the day symptoms appear, the false negative rate was 38%; it dropped to 20% on the third day and increased to 66% two weeks later.²⁸

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According to Stephen Rawlings, MD PhD, infectious disease fellow at UC San Diego Center for AIDS research, one of the problems is that there is nothing to compare current tests to. He says, "To truly determine false negatives, you need a gold standard test, which is essentially as close to perfect as we can get," Rawlings said. "But there just isn't one yet for coronavirus."

Colin West MD PhD at Mayo Clinic says that the studies that have looked at accuracy of tests currently used have been "filled with flaws," one of which is that the sensitivity estimates are based on testing people who the researchers already knew had COVID-19. This results in significant bias. He says that without control groups of blinded testing it's impossible to determine the magnitude of the inaccuracy.²⁹

The results of an analysis of five studies that included 957 patients and that had yet to be peer-reviewed concluded that "The certainty of the evidence was judged as very low, due to the risk of bias, indirectness, and inconsistency issues. Conclusions: The collected evidence has several limitations, including risk of bias issues, high heterogeneity, and concerns about its applicability."³⁰

Other Countries Inflated Numbers Too

Public health officials in the UK have inflated the number of cases by counting each test twice. When diagnostic tests were used that involved taking both saliva and nasal samples from the same patient, the results were counted as two separate tests. This led to inflated case numbers. Both the Department of Health and Social Care and Public Health England acknowledged that they had engaged in this practice.

This is not the only instance in which the UK government was caught inflating data. In April, public health authorities included thousands of home tests which had been mailed out but not completed in order to make it look like the goal of 100,000 tests was being met.

Apparently using fake numbers to promote a fake pandemic is not limited to the U.S.³¹

The CDC's Strange Definition of a "Case"

As you have seen, the tests were definitely flawed. But the CDC's definition of a "case" did not require any testing at all. The CDC listed over one dozen ways in which a person could be diagnosed with COVID-19.

Here are excerpts from the CDC's "2020 Interim Case Definition"³² (verbatim with commentary)

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Clinical Criteria

At least two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)

OR

At least one of the following symptoms: cough, shortness of breath, or difficulty breathing

OR

Severe respiratory illness with at least one of the following:

Clinical or radiographic evidence of pneumonia **OR**

Acute respiratory distress syndrome

AND

No alternative more likely diagnosis

Commentary on "Clinical Criteria"

Note that fever can be "subjective."

Headache, sore throat and cough can be symptoms of many things, including the common cold.

"New olfactory and taste disorders" An article published in the *Lancet* referred to COVID testing as "inadequate" and suggests that new symptom profiles be developed to help identify those who should be quarantined.

It suggests that loss of taste and smell are highly predictive of COVID-19 and anyone experiencing these symptoms should self-isolate.³³

In fact, there are many causes of loss of taste and smell. These include:

Aging especially after age 60

Allergies

Nasal and sinus problems like sinusitis or nasal polyps

Medications including beta blockers and ACE inhibitors

Dental problems

Cigarette smoking

Head or facial injury

Alzheimer's disease

Parkinson's disease

Common cold or other viral infections (40%)³⁴

In fact, as much as 20% of the general population has a prolonged smell disorder.³⁵

There are many problems with the *Lancet* article. The basis for the recommendation to use taste and smell as a diagnostic tool is data collected from patients using an online app. Almost 60% of 579 people who reported testing positive said they had lost their

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sense of smell and taste; but almost 18% of the 1123 who tested negative also reported loss of taste and smell.³⁶

The researchers acknowledge many limitations which include that these symptoms are non-specific and lack predictive power, and their report relied on self-reported information, which is generally unreliable. Yet, they write, "We believe that having added loss of smell and taste to the list of COVID-19 symptoms is of great value as it will help trace almost 16% of cases that otherwise would have been missed. Loss of smell and taste, together with fever or cough, should now enable us to identify 87.5% of symptomatic COVID-19 cases, although this is likely to be less in the early phases of the infection." This conclusion is hard to fathom in consideration of the facts, although facts have not seemed to matter much these days.

Here's a much more realistic assessment from Eric Holbrook, director of rhinology at Massachusetts Eye and Ear: "Physicians are collecting data so quickly, but a lot of it is subjective data. I haven't seen a careful study that looks at when patients get the diagnosis, and how severe it is, and how long the smell loss lasts."³⁷

Laboratory Criteria

Laboratory evidence using a method approved or authorized by the U.S. Food and Drug Administration (FDA) or designated authority:

Confirmatory laboratory evidence:

- Detection of severe acute respiratory syndrome coronavirus 2 ribonucleic acid (SARS-CoV-2 RNA) in a clinical specimen using a molecular amplification detection test

Presumptive laboratory evidence:

- Detection of specific antigen in a clinical specimen
- Detection of specific antibody in serum, plasma, or whole blood indicative of a new or recent infection*

**Serologic methods for diagnosis are currently being defined*

Commentary on Laboratory Criteria:

Note that these are the tests we proved were inaccurate, and that the CDC admits that the serological methods for diagnosis are currently being defined, but they are ok to use for purposes of diagnosis now.

Epidemiologic Linkage

One or more of the following exposures in the 14 days before onset of symptoms:

- Close contact** with a confirmed or probable case of COVID-19 disease; **OR**
- Close contact** with a person with:
 - clinically compatible illness **AND**
 - linkage to a confirmed case of COVID-19 disease.

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- Travel to or residence in an area with sustained, ongoing community transmission of SARS-CoV-2.
- Member of a risk cohort as defined by public health authorities during an outbreak.

***Close contact is defined as being within 6 feet for at least a period of 10 minutes to 30 minutes or more depending upon the exposure. In healthcare settings, this may be defined as exposures of greater than a few minutes or more. Data are insufficient to precisely define the duration of exposure that constitutes prolonged exposure and thus a close contact.*

Commentary on Epidemiologic Linkage:

A person who has been within 6 feet of someone for 10 minutes who may have but is not confirmed to have COVID-19 is now considered a case

A person who has been within 6 feet of a person who has a headache or a sore throat, or has changes in smell or taste is now considered a case

A person who has been in contact with a person who is linked to a person with COVID-19 is now a case.

Travel to an area in which there are COVID-19 cases qualifies a person as a case.

Being a member of a "risk cohort" also qualifies a person as a case. There are no examples, but a statement that health authorities can just name a group as a risk category.

The CDC acknowledges that it is not known the length of exposure required to cause a problem but uses this metric anyway.

Criteria to Distinguish a New Case from an Existing Case

Not applicable (N/A) until more virologic data are available.

Commentary on Criteria to Distinguish a New Case from an Existing Case:

The CDC does not know how to determine a new from an existing case, but when trying to gin up cases, what difference could this make?

Ginning Up the Death Rate

According the CDC's document titled "Guidance for Certifying Deaths Due to Coronavirus Disease 2019 (COVID-19)":³⁸

"In cases where a definite diagnosis of COVID cannot be made but is suspected or likely (e.g. the circumstances are compelling with a reasonable degree of

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certainty) it is acceptable to report COVID-19 on a death certificate as 'probable' or 'presumed.'"

In other words, when in doubt, classify any death possible as COVID-19, which will serve to inflate the numbers to make it look like the projections are right and keep the hoax alive.

The National Vital Statistics System issued an alert on March 24, 2020 regarding a new ICD code for COVID-19 deaths. According to this document:

The WHO has provided a second code, **U07.2**, for clinical or epidemiological diagnosis of COVID-19 where a laboratory confirmation is inconclusive or not available.

Will COVID-19 be the underlying cause?

The underlying cause depends upon what and where conditions are reported on the death certificate. However, the rules for coding and selection of the underlying cause of death are expected to result in COVID-19 being the underlying cause more often than not.

Should "COVID-19" be reported on the death certificate only with a confirmed test?

COVID-19 should be reported on the death certificate for all decedents where the disease caused **or is assumed to have caused or contributed to death.**³⁹

Again, specific instructions to list the cause of death as COVID-19 as much as possible.

Dr. Deborah Birx, a member of the White House task force, confirmed this. She announced during a press briefing on Tuesday April 7, 2020 that the deaths of all patients who died with coronavirus, even if the cause of death was not due to COVID-19, should list COVID-19 as cause of death on the death certificate. She acknowledged that other countries do not do this. "There are other countries that if you had a pre-existing condition, and let's say the virus caused you to go to the ICU [intensive care unit] and then have a heart or kidney problem...Some countries are recording that as a heart issue or a kidney issue and not a COVID-19 death. The intent is ... if someone dies with COVID-19 we are counting that."⁴⁰

Dr. Scott Jensen, a Minnesota Family practice doctor and state Senator, said that this means that a patient who died after being hit by a bus and tested positive for coronavirus would be listed as having presumed to have died from the virus regardless of whatever damage was caused by the bus.

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Dr. Jensen reported receiving a 7-page document from CDC instructing him to do this. As for the motivation? "Fear is a great way to control people," he told a television station.⁴¹

He was notably outspoken about this matter. He cited situations in the past where he had patients who died while having the flu, stating "I've never been encouraged to [notate 'influenza']. I would probably write 'respiratory arrest' to be the top line, and the underlying cause of this disease would be pneumonia ... I might well put emphysema or congestive heart failure, but I would never put influenza down as the underlying cause of death and yet that's what we are being asked to do here."⁴²

When Dr. Anthony Fauci was asked about the number of coronavirus deaths being "padded," he cited the prevalence of "conspiracy theories" during "challenging" times in public health. Dr. Jensen's response to this was "I would remind him that anytime health care intersects with dollars it gets awkward." Dr. Jensen stated that Medicare provides \$13,000 to the hospitals and doctors for each COVID-19 patient, much more than the standard for ailments such as influenza, which has averaged around \$5,000 in recent years. In addition to that, if a ventilator is used for the patient, Medicare provides \$39,000 to the hospital and doctors.⁴³ Although Dr. Jensen did not go as far as saying that physicians are trying to pad their pockets, he is more skeptical of those at higher levels such as hospital administrators.

Other misrepresentations about cause of death were being made almost daily. For example, during a press conference, Connecticut Governor Ned Lamont announced that a 6-week-old baby had died and tested positive for coronavirus, and that this was likely one of the youngest deaths from the disease anywhere.⁴⁴ His tweet read: "It is with heartbreaking sadness today that we can confirm the first pediatric fatality in Connecticut linked to COVID-19. A 6-week-old newborn from the Hartford area was brought unresponsive to a hospital late last week and could not be revived." He went on to say, "This is a virus that attacks our most fragile without mercy. This also stresses the importance of staying home and limiting exposure to other people. Your life and the lives of others could literally depend on it. Our prayers are with the family at this difficult time."⁴⁵

The problem is that this is not what happened at all. In fact, the state's medical examiner refused to certify death from coronavirus. Toxicology tests are pending, and the medical examiner indicated the possibility that the child had an underlying condition or might have died of sudden infant death syndrome or positional asphyxiation.⁴⁶

But the damage was done. Lamont told the public that "...no one is safe from this virus," and issued this warning, "For those young people who think maybe they're a little more invincible, think again."⁴⁷ The public became more frightened, more likely to do as they were told. Stay home, do not congregate, continue to follow directions. He succeeded in scaring people with a false story.

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This is not the only example in which a young person was said to have died from COVID-19 when that is not what happened at all. Chloe Middleton, age 21, died from coronavirus, according to her family. She was taken to the hospital after having a heart attack and died shortly after. A coroner said the cause of death was related to COVID-19 because the family reported she had a cough. The hospital had not recorded it as a COVID-19 death because she did not test positive for the disease.

The family took down a Facebook post claiming that Chloe had no underlying health issues and refused to respond to reporters calling for information. Subsequently the coroner's office issued this statement: "Chloe died at Wexham Park Hospital on the 19 March 2020. The case was reported to the Berkshire coroner's office. Her death was very sad but as she had a natural cause of death, involvement by the coroner was not required and the hospital issued a death certificate. There was no postmortem examination or inquest. We must now respect the privacy of her family and cannot provide any further information."⁴⁸

There's More

A study published in April 2020 showed that it is difficult to differentiate between deaths from COVID-19 and Radiation Pneumonitis (RP), which is a common condition that occurs in 15-40% of patients being treated for cancer.⁴⁹ Cancer patients are more susceptible to getting the flu and dying from it. We will never know how many were improperly diagnosed or reported, yet it is important to note.

Inaccurate State Death Reports

The *New York Times* reported on April 14, 2020 that New York City had increased its death toll by 3700 people after officials said they would not include people who never tested positive for COVID-19 but were assumed to have it.

After admitting that the cases were not valid, the *Times* reporters wrote, "The numbers brought into clearer focus the staggering toll the virus has already taken on the largest city in the United States, where deserted streets are haunted by the near-constant howl of ambulance sirens."⁵⁰

In Pennsylvania, death rates were adjusted downward when Health Secretary Rachel Levine said on April 23, 2020 that more information is needed before "probable" cases can be attributed to COVID-19. She said the decision was made in the interest of transparency.

This decision resulted in a reduction of 6 deaths in Lehigh County, and 100 fewer deaths in Philadelphia, 2 fewer in Montgomery County. Bucks county saw a reduction of

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10, Monroe county was reduced by 6, and Carbon County was reduced by 2. Total drop was 200 deaths, a significant percentage of the total.⁵¹

On April 20, 2020, Illinois Department of Health Director Dr. Ngozi Ezike explained how her department decides whether a death is due to COVID-19. She said that anyone who dies and has tested positive is categorized as a COVID-19 death.

Here is, verbatim, what she said:

"If you were in hospice and had already been given a few weeks to live, and then you also were found to have COVID, that would be counted as a COVID death. It means technically even if you died of a clear alternate cause, but you had COVID at the same time, it's still listed as a COVID death. So, everyone who's listed as a COVID death doesn't mean that that was the cause of the death, but they had COVID at the time of the death."⁵²

Colorado State representative Mark Baisley has asked for a formal investigation into Jill Ryan, Executive Director of the Colorado Department of Public Health and Environment with the potential for criminal charges to be brought. According to Baisley, Ryan has falsely altered death certificates.

Baisley provided a letter from the Someren Glen senior care facility which was sent to its staff, residents, and families of residents, stating that CPDHE had changed the cause of death recorded by attending physicians in seven cases to reflect COVID-19 instead of the actual cause of death.

The Montezuma County coroner told the same news station that the state overruled the cause of death for a person in his jurisdiction too. The person died of alcohol poisoning, but it was changed to COVID-19.

Eventually the Colorado Department of Health acknowledged that the numbers had been inflated by people who had the virus but died of other causes and adjusted the numbers down from 1150 deaths to 878.⁵³

Dr. Deborah Birx, the task force response coordinator, changed her tune about death counts. During a previous White House daily briefing she stated that death certificates were to state COVID-19 as the cause of death if the person tested positive but died of something else. She said the opposite and asked the CDC to exclude from the death count people who had the virus but died of something else and removed those who were presumed to have the virus but did not have confirmed lab results.

Birx and other health officials take issue with the CDC's system now, claiming that the number of cases and mortality may be inflated as much as 25%. "There is nothing from the CDC that I can trust," she told CDC Director Robert Redfield.⁵⁴

Attachment C

In June 2020, Washington State announced a "phased-in" process which would result in telling the truth about COVID-19 deaths. Apparently just telling the truth all at once would be intolerable. The first phase resulted in several suicides, homicides, and overdose deaths being removed from the death count. Health officials also reported that they would categorize deaths as "confirmed, probable, suspect and not COVID."

The Freedom Foundation investigated and reported on this May 18, 2020 after obtaining written data from Washington State DOH officials. When confronted with it, Washington Governor Inslee responded that it was disgusting and malarkey and accused the Freedom Foundation of "fanning these conspiracy claims from the planet Pluto" and not caring about people who died from COVID.⁵⁵

DOH held a press briefing on May 21, 2020 during which it confirmed that reported deaths were inflated and that "(w)e currently do have some deaths that are being reported that are clearly from other causes" including some "...from gunshot wounds."

Some "Deaths" Were Clearly NOT COVID!

Coal miner Nathan Turner was 30 years old when he was found dead in his home by his fiancé in Queensland, Australia. Queensland Health promptly reported that Turner died of coronavirus and claimed that he was Australia's youngest COVID-19 victim. Local doctors reported that Turner's death baffled them as he had not left his small town since February. They hypothesize that perhaps a nurse from 400 km away who had driven to Blackwater to watch the sunset had infected him.

After all of this, autopsy showed that Turner did not have the virus. The family was furious and called on Premier Annastacia Palaszczuk and health official Jeannette Young to apologize to both the family and to the community for creating "chaos and panic."

"You should be ashamed of yourself and if you had any human decency left then you will apologise for creating trauma to this family whilst you caused panic to our community.

"This is unacceptable behaviour from our leaders in power who forced a family to sit in silence and not to comment about the chaos they were about to inflict on our state."

Queensland Health admits administering additional tests which also were negative for COVID. Apparently, there are many who are intent on making a diagnosis of COVID even when it is not there.

An online petition demanding a truthful apology had gathered 2092 signatures out of 2500 goal within just a few hours.⁵⁶

Attachment C

One of the more insane episodes of deaths categorized as COVID-19 involved a man who was shot by the NYPD after threatening officers with a knife and gun.

Ricardo Cardona called 911 on himself and then repeatedly told officers to kill him when they arrived to find him with the weapons. He later told investigators that he wanted to die by suicide by cop since he had been infected with COVID-19. The officers ultimately fired 11 shots, 7 of which hit him. He died 5 days later, and his death is attributed to COVID-19 with his wounds and underlying health conditions listed as "complicating factors."⁵⁷

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Attachment C

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[0/fulltext?fbclid=IwAR0dOy2N74mrwd-AeVPjCTGOY-d3dFFM4mTB4JU-Xk7ZjbcXi5hHm-p5VZU#](https://www.thegreenjournal.com/article/S0167-8140(20)30190-0/fulltext?fbclid=IwAR0dOy2N74mrwd-AeVPjCTGOY-d3dFFM4mTB4JU-Xk7ZjbcXi5hHm-p5VZU#)

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CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel

For Emergency Use Only

Instructions for Use

**Catalog # 2019-nCoV EUA-01
1000 reactions**

For *In-vitro* Diagnostic (IVD) Use

Rx Only

Centers for Disease Control and Prevention
Division of Viral Diseases
1600 Clifton Rd NE
Atlanta GA 30329



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Intended Use

The CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel is a real-time RT-PCR test intended for the qualitative detection of nucleic acid from the 2019-nCoV in upper and lower respiratory specimens (such as nasopharyngeal or oropharyngeal swabs, sputum, lower respiratory tract aspirates, bronchoalveolar lavage, and nasopharyngeal wash/aspirate or nasal aspirate) collected from individuals who meet 2019-nCoV clinical and/or epidemiological criteria (for example, clinical signs and symptoms associated with 2019-nCoV infection, contact with a probable or confirmed 2019-nCoV case, history of travel to geographic locations where 2019-nCoV cases were detected, or other epidemiologic links for which 2019-nCoV testing may be indicated as part of a public health investigation). Testing in the United States is limited to laboratories certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 U.S.C. § 263a, to perform high complexity tests.

Results are for the identification of 2019-nCoV RNA. The 2019-nCoV RNA is generally detectable in upper and lower respiratory specimens during infection. Positive results are indicative of active infection with 2019-nCoV but do not rule out bacterial infection or co-infection with other viruses. The agent detected may not be the definite cause of disease. Laboratories within the United States and its territories are required to report all positive results to the appropriate public health authorities.

Negative results do not preclude 2019-nCoV infection and should not be used as the sole basis for treatment or other patient management decisions. Negative results must be combined with clinical observations, patient history, and epidemiological information.

Testing with the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel is intended for use by trained laboratory personnel who are proficient in performing real-time RT-PCR assays. The CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel is only for use under a Food and Drug Administration's Emergency Use Authorization.

Summary and Explanation

An outbreak of pneumonia of unknown etiology in Wuhan City, Hubei Province, China was initially reported to WHO on December 31, 2019. Chinese authorities identified a novel coronavirus (2019-nCoV), which has resulted in millions of confirmed human infections globally. Cases of asymptomatic infection, mild illness, severe illness, and deaths have been reported.

The CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel is a molecular *in vitro* diagnostic test that aids in the detection and diagnosis 2019-nCoV and is based on widely used nucleic acid amplification technology. The product contains oligonucleotide primers and dual-labeled hydrolysis probes (TaqMan®) and control material used in rRT-PCR for the *in vitro* qualitative detection of 2019-nCoV RNA in respiratory specimens.

The term "qualified laboratories" refers to laboratories in which all users, analysts, and any person reporting results from use of this device should be trained to perform and interpret the results from this procedure by a competent instructor prior to use.

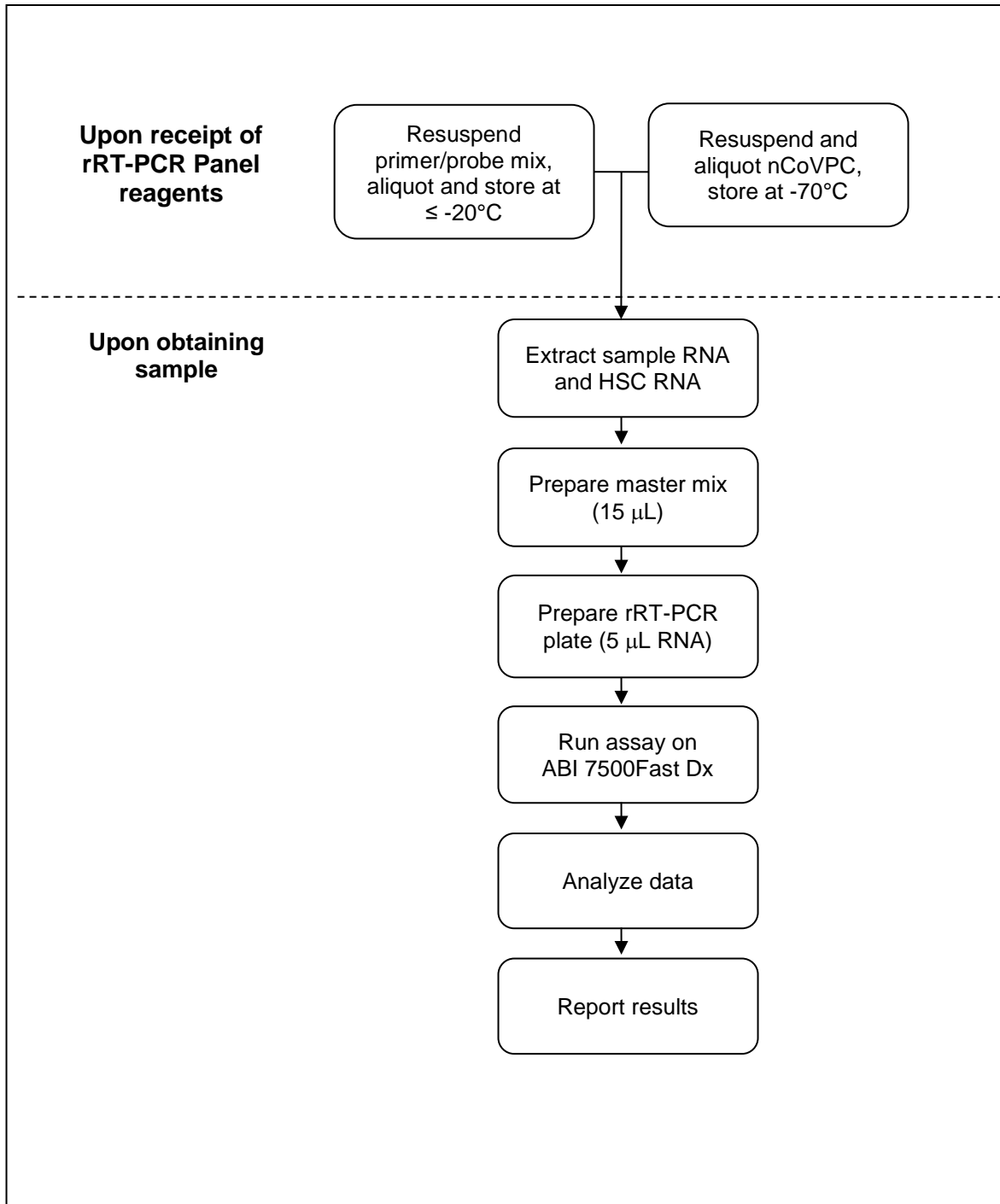
Principles of the Procedure

The oligonucleotide primers and probes for detection of 2019-nCoV were selected from regions of the virus nucleocapsid (N) gene. The panel is designed for specific detection of the 2019-nCoV (two primer/probe sets). An additional primer/probe set to detect the human RNase P gene (RP) in control samples and clinical specimens is also included in the panel.

RNA isolated and purified from upper and lower respiratory specimens is reverse transcribed to cDNA and subsequently amplified in the Applied Biosystems 7500 Fast Dx Real-Time PCR Instrument with SDS version 1.4 software. In the process, the probe anneals to a specific target sequence located between the forward and reverse primers. During the extension phase of the PCR cycle, the 5' nuclease activity of Taq polymerase degrades the probe, causing the reporter dye to separate from the quencher dye, generating a fluorescent signal. With each cycle, additional reporter dye molecules are cleaved from their respective probes, increasing the fluorescence intensity. Fluorescence intensity is monitored at each PCR cycle by Applied Biosystems 7500 Fast Dx Real-Time PCR System with SDS version 1.4 software.

Detection of viral RNA not only aids in the diagnosis of illness but also provides epidemiological and surveillance information.

Summary of Preparation and Testing Process



Materials Required (Provided)

Note: CDC will maintain on its website a list of commercially available lots of primer and probe sets and/or positive control materials that are acceptable alternatives to the CDC primer and probe set and/or positive control included in the Diagnostic Panel. Only material distributed through the CDC International Reagent Resource and specific lots of material posted to the CDC website are acceptable for use with this assay under CDC's Emergency Use Authorization.

This list of acceptable alternative lots of primer and probe materials and/or positive control materials will be available at:

<https://www.cdc.gov/coronavirus/2019-nCoV/lab/virus-requests.html>

Primers and Probes:**Catalog #2019-nCoV-EUA-01 Diagnostic Panel Box #1:**

<i>Reagent Label</i>	<i>Part #</i>	<i>Description</i>	<i>Quantity / Tube</i>	<i>Reactions / Tube</i>
2019-nCoV_N1	RV202001 RV202015	2019-nCoV_N1 Combined Primer/Probe Mix	22.5 nmol	1000
2019-nCoV_N2	RV202002 RV202016	2019-nCoV_N2 Combined Primer/Probe Mix	22.5 nmol	1000
RP	RV202004 RV202018	Human RNase P Combined Primer/Probe Mix	22.5 nmol	1000

Positive Control (either of the following products are acceptable)**Catalog #2019-nCoV-EUA-01 Diagnostic Panel Box #2:**

<i>Reagent Label</i>	<i>Part #</i>	<i>Description</i>	<i>Quantity</i>	<i>Notes</i>
nCoVPC	RV202005	2019-nCoV Positive Control (nCoVPC) For use as a positive control with the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel procedure. The nCoVPC contains noninfectious positive control material supplied in a dried state and must be resuspended before use. nCoVPC consists of <i>in vitro</i> transcribed RNA. nCoVPC will yield a positive result with each assay in the 2019-nCoV Real-Time RT-PCR Diagnostic Panel including RP.	4 tubes	Provides (800) 5 µL test reactions

Catalog #VTC-04 CDC 2019-nCoV Positive Control (nCoVPC)

Reagent Label	Part #	Description	Quantity	Notes
nCoVPC	RV202005	2019-nCoV Positive Control (nCoVPC) For use as a positive control with the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel procedure. The nCoVPC contains noninfectious positive control material supplied in a dried state and must be resuspended before use. nCoVPC consists of <i>in vitro</i> transcribed RNA. nCoVPC will yield a positive result with each assay in the 2019-nCoV Real-Time RT-PCR Diagnostic Panel including RP.	4 tubes	Provides (800) 5 µL test reactions

Materials Required (But Not Provided)**Human Specimen Control (HSC)**

Description	Quantity	CDC Catalog No.
Manufactured by CDC. For use as a nucleic acid extraction procedural control to demonstrate successful recovery of nucleic acid as well as extraction reagent integrity. The HSC consists of noninfectious (beta-Propiolactone treated) cultured human cell material supplied as a liquid suspended in 0.01 M PBS at pH 7.2-7.4.	10 vials x 500uL	KT0189

Acceptable alternatives to HSC:

- Negative human specimen material: Laboratories may prepare a volume of human specimen material (e.g., human sera or pooled leftover negative respiratory specimens) to extract and run alongside clinical samples as an extraction control. This material should be prepared in sufficient volume to be used across multiple runs. Material should be tested prior to use as the extraction control to ensure it generates the expected results for the HSC listed in these instructions for use.
- Contrived human specimen material: Laboratories may prepare contrived human specimen materials by suspending any human cell line (e.g., A549, HeLa, or 293) in PBS. This material should be prepared in sufficient volume to be used across multiple runs. Material should be tested prior to use as the extraction control to ensure it generates the expected results for the HSC listed in these instructions for use.

CDC will maintain on its website a list of commercially alternative extraction controls, if applicable, that are acceptable for use with this assay under CDC's Emergency Use Authorization, at:

<https://www.cdc.gov/coronavirus/2019-nCoV/lab/virus-requests.html>

rRT-PCR Enzyme Mastermix Options

Reagent	Quantity	Catalog No.
Quantabio qScript XLT One-Step RT-qPCR ToughMix	100 x 20 µL rxns (1 x 1 mL)	95132-100
	2000 x 20 µL rxns (1 x 20 mL)	95132-02K
	500 x 20 µL rxns (5 x 1 mL)	95132-500
Quantabio UltraPlex 1-Step ToughMix (4X)	100 x 20 µL rxns (500 µL)	95166-100
	500 x 20 µL rxns (5 x 500 µL)	95166-500
	1000 x 20 µL rxns (1 x 5 mL)	95166-01K
Promega GoTaq® Probe 1- Step RT-qPCR System	200 x 20 µL rxns (2 mL)	A6120
	1250 x 20 µL rxns 12.5 mL	A6121
Thermofisher TaqPath™ 1-Step RT-qPCR Master Mix, CG	1000 reactions	A15299
	2000 reactions	A15300

RNA Extraction Options

For each of the kits listed below, CDC has confirmed that the external lysis buffer is effective for inactivation of SARS-CoV-2.

Instrument/Manufacturer	Extraction Kit	Catalog No.
QIAGEN	² QIAamp DSP Viral RNA Mini Kit	50 extractions (61904)
	² QIAamp Viral RNA Mini Kit	50 extractions (52904) 250 extractions (52906)
QIAGEN EZ1 Advanced XL	² EZ1 DSP Virus Kit	48 extractions (62724) Buffer AVL (19073 or 19089) EZ1 Advanced XL DSP Virus Card (9018703)
	² EZ1 Virus Mini Kit v2.0	48 extractions (955134) Buffer AVL (19073 or 19089) EZ1 Advanced XL Virus Card v2.0 (9018708)
Roche MagNA Pure 24	² MagNA Pure 24 Total NA Isolation Kit	96 extractions (07 658 036 001) External Lysis Buffer (06 374 913 001, 12 239 469 103, 03 246 779 001 or 03 246 752 001)
Roche MagNA Pure 96	² DNA and Viral NA Small Volume Kit	576 extractions (06 543 588 001) External Lysis Buffer (06 374 913 001, 12 239 469 103, 03 246 779 001 or 03 246 752 001)
¹ Roche MagNA Pure LC	² Total Nucleic Acid Kit	192 extractions (03 038 505 001)
¹ Roche MagNA Pure Compact	² Nucleic Acid Isolation Kit I	32 extractions (03 730 964 001)
Promega Maxwell® RSC 48	³ Maxwell® RSC Viral Total Nucleic Acid Purification Kit	48 extractions (AS1330) 144 extractions (ASB1330)
¹ QIAGEN QIAcube	² QIAamp DSP Viral RNA Mini Kit	50 extractions (61904)
	² QIAamp Viral RNA Mini Kit	50 extractions (52904) 250 extractions (52906)
^{1, 3} bioMérieux NucliSENS® easyMAG® and ^{1, 3} bioMérieux EMAG® (Automated magnetic extraction reagents sold separately. Both instruments use the same reagents and disposables, with the exception of tips.)		EasyMAG® Magnetic Silica (280133) EasyMAG® Lysis Buffer (280134) EasyMAG® Lysis Buffer, 2 mL (200292) EasyMAG® Wash Buffers 1,2, and 3 (280130, 280131, 280132) EasyMAG® Disposables (280135) Biohit Pipette Tips (easyMAG® only) (280146) EMAG®1000µL Tips (418922)

¹Equivalence and performance of these extraction platforms for extraction of viral RNA were demonstrated with the CDC Human Influenza Virus Real-Time RT-PCR Diagnostic Panel (K190302). Performance characteristics of these extraction platforms with 2019-nCoV (SARS CoV-2) have not been demonstrated.

² CDC has confirmed that the external lysis buffer used with this extraction method is effective for inactivation of SARS-CoV-2.

³ CDC has compared the concentration of inactivating agent in the lysis buffer used with this extraction method and has determined the concentration to be within the range of concentrations found effective in inactivation of SARS-CoV-2.

Alternative to Extraction:

If a laboratory cannot access adequate extraction reagents to support testing demand due to the global shortage of reagents, CDC has evaluated a heat treatment procedure for upper respiratory specimens using the Quantabio UltraPlex 1-Step ToughMix (4X), CG. Though performance was comparable, this method has been evaluated with a limited number of clinical specimens and a potential reduction in sensitivity due to carryover of inhibitory substances or RNA degradation cannot be ruled out. It should only be used when a jurisdiction determines that the testing need is great enough to justify the risk of a potential loss of sensitivity. Heat-treated specimens generating inconclusive or invalid results should be extracted with an authorized extraction method prior to retesting. Details and procedure for the heat treatment alternative to extraction may be found in Appendix A.

Equipment and Consumables Required (But Not Provided)

- Vortex mixer
- Microcentrifuge
- Micropipettes (2 or 10 µL, 200 µL and 1000 µL)
- Multichannel micropipettes (5-50 µl)
- Racks for 1.5 mL microcentrifuge tubes
- 2 x 96-well -20°C cold blocks
- 7500 Fast Dx Real-Time PCR Systems with SDS 1.4 software (Applied Biosystems; catalog #4406985 or #4406984)
- Extraction systems (instruments): QIAGEN EZ1 Advanced XL, QIAGEN QIAcube, Roche MagNA Pure 24, Roche MagNA Pure 96, Promega Maxwell® RSC 48, Roche MagNA Pure LC, Roche MagNA Pure Compact, bioMérieux easyMAG, and bioMérieux EMAG
- Molecular grade water, nuclease-free
- 10% bleach (1:10 dilution of commercial 5.25-6.0% hypochlorite bleach)
- DNAPrep™ (Ambion, cat. #AM9890) or equivalent
- RNase AWAY™ (Fisher Scientific; cat. #21-236-21) or equivalent
- Disposable powder-free gloves and surgical gowns
- Aerosol barrier pipette tips
- 1.5 mL microcentrifuge tubes (DNase/RNase free)
- 0.2 mL PCR reaction plates (Applied Biosystems; catalog #4346906 or #4366932)
- MicroAmp Optical 8-cap Strips (Applied Biosystems; catalog #4323032)

Qualifying Alternative Components:

If a laboratory modifies this test by using unauthorized, alternative components (e.g., extraction methods or PCR instruments), the modified test is not authorized under this EUA. FDA's Policy for Diagnostic Tests for Coronavirus Disease-2019 during the Public Health Emergency, updated May 11, 2020, does not change this. As part of this policy, FDA does not intend to object when a laboratory modifies an EUA-authorized test, which could include using unauthorized components, without

obtaining an EUA or EUA amendment, where the modified test is validated using a bridging study to the EUA-authorized test .

Warnings and Precautions

- For *in vitro* diagnostic use (IVD).
 - This test has not been FDA cleared or approved; this test has been authorized by FDA under an EUA for use by laboratories certified under CLIA, 42 U.S.C. § 263a, to perform high complexity tests.
 - This test has been authorized only for the detection of nucleic acid from SARS-CoV-2, not for any other viruses or pathogens.
 - This test is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of *in vitro* diagnostic tests for detection and/or diagnosis of COVID-19 under Section 564(b)(1) of the Act, 21 U.S.C. § 360bbb-3(b)(1), unless the authorization is terminated or revoked sooner.
- Follow standard precautions. All patient specimens and positive controls should be considered potentially infectious and handled accordingly.
- Do not eat, drink, smoke, apply cosmetics or handle contact lenses in areas where reagents and human specimens are handled.
- Handle all specimens as if infectious using safe laboratory procedures. Refer to Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with 2019-nCoV <https://www.cdc.gov/coronavirus/2019-nCoV/lab-biosafety-guidelines.html>.
- Specimen processing should be performed in accordance with national biological safety regulations.
- If infection with 2019-nCoV is suspected based on current clinical and epidemiological screening criteria recommended by public health authorities, specimens should be collected with appropriate infection control precautions.
- Performance characteristics have been determined with human upper respiratory specimens and lower respiratory tract specimens from human patients with signs and symptoms of respiratory infection.
- Perform all manipulations of live virus samples within a Class II (or higher) biological safety cabinet (BSC).
- Use personal protective equipment such as (but not limited to) gloves, eye protection, and lab coats when handling kit reagents while performing this assay and handling materials including samples, reagents, pipettes, and other equipment and reagents.
- Amplification technologies such as PCR are sensitive to accidental introduction of PCR product from previous amplifications reactions. Incorrect results could occur if either the clinical specimen or the real-time reagents used in the amplification step become contaminated by accidental introduction of amplification product (amplicon). Workflow in the laboratory should proceed in a unidirectional manner.
 - Maintain separate areas for assay setup and handling of nucleic acids.
 - Always check the expiration date prior to use. Do not use expired reagents. Do not substitute or mix reagents from different kit lots or from other manufacturers.
 - Change aerosol barrier pipette tips between all manual liquid transfers.
 - During preparation of samples, compliance with good laboratory techniques is essential to minimize the risk of cross-contamination between samples and the inadvertent

introduction of nucleases into samples during and after the extraction procedure. Proper aseptic technique should always be used when working with nucleic acids.

- Maintain separate, dedicated equipment (e.g., pipettes, microcentrifuges) and supplies (e.g., microcentrifuge tubes, pipette tips) for assay setup and handling of extracted nucleic acids.
- Wear a clean lab coat and powder-free disposable gloves (not previously worn) when setting up assays.
- Change gloves between samples and whenever contamination is suspected.
- Keep reagent and reaction tubes capped or covered as much as possible.
- Primers, probes (including aliquots), and enzyme master mix must be thawed and maintained on a cold block at all times during preparation and use.
- Work surfaces, pipettes, and centrifuges should be cleaned and decontaminated with cleaning products such as 10% bleach, DNAZap™, or RNase AWAY™ to minimize risk of nucleic acid contamination. Residual bleach should be removed using 70% ethanol.
- RNA should be maintained on a cold block or on ice during preparation and use to ensure stability.
- Dispose of unused kit reagents and human specimens according to local, state, and federal regulations.

Reagent Storage, Handling, and Stability

- Store all dried primers and probes and the positive control, nCoVPC, at 2-8°C until re-hydrated for use. Store liquid HSC control materials at $\leq -20^{\circ}\text{C}$.
Note: Storage information is for CDC primer and probe materials obtained through the International Reagent Resource. If using commercial primers and probes, please refer to the manufacturer's instructions for storage and handling.
- Always check the expiration date prior to use. Do not use expired reagents.
- Protect fluorogenic probes from light.
- Primers, probes (including aliquots), and enzyme master mix must be thawed and kept on a cold block at all times during preparation and use.
- Do not refreeze probes.
- Controls and aliquots of controls must be thawed and kept on ice at all times during preparation and use.

Specimen Collection, Handling, and Storage

Inadequate or inappropriate specimen collection, storage, and transport are likely to yield false test results. Training in specimen collection is highly recommended due to the importance of specimen quality. CLSI MM13-A may be referenced as an appropriate resource.

➤ Collecting the Specimen

- Refer to Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for 2019 Novel Coronavirus (2019-nCoV) <https://www.cdc.gov/coronavirus/2019-nCoV/guidelines-clinical-specimens.html>
- Follow specimen collection device manufacturer instructions for proper collection methods.
- Swab specimens should be collected using only swabs with a synthetic tip, such as nylon or Dacron®, and an aluminum or plastic shaft. Calcium alginate swabs are unacceptable and cotton swabs with wooden shafts are not recommended. Place swabs immediately into sterile tubes containing 1-3 ml of appropriate transport media, such as viral transport media (VTM).

➤ Transporting Specimens

- Specimens must be packaged, shipped, and transported according to the current edition of the International Air Transport Association (IATA) Dangerous Goods Regulation. Follow shipping regulations for UN 3373 Biological Substance, Category B when sending potential 2019-nCoV specimens. Store specimens at 2-8°C and ship overnight to CDC on ice pack. If a specimen is frozen at -70°C or lower, ship overnight to CDC on dry ice.

➤ Storing Specimens

- Specimens can be stored at 2-8°C for up to 72 hours after collection.
- If a delay in extraction is expected, store specimens at -70°C or lower.
- Extracted nucleic acid should be stored at -70°C or lower.

Specimen Referral to CDC

For state and local public health laboratories:

- Ship all specimens overnight to CDC.
- Ship frozen specimens on dry ice and non-frozen specimens on cold packs.
- Refer to the International Air Transport Association (IATA - www.iata.org) for requirements for shipment of human or potentially infectious biological specimens. Follow shipping regulations for UN 3373 Biological Substance, Category B when sending potential 2019-nCoV specimens.
- Prior to shipping, notify CDC Division of Viral Diseases (see contact information below) that you are sending specimens.
- Send all samples to the following recipient:

Centers for Disease Control and Prevention
c/o STATT
Attention: Unit 66
1600 Clifton Rd., Atlanta, GA 30329-4027
Phone: (404) 639-3931

**The emergency contact number for CDC Emergency Operations Center (EOC) is
770-488-7100.**

All other laboratories that are CLIA certified and meet requirements to perform high complexity testing:

- Please notify your state and/or local public health laboratory for specimen referral and confirmatory testing guidance.

Reagent and Controls Preparation

NOTE: Storage information is for materials obtained through the CDC International Regent Resource. If using commercial products for testing, please refer to the manufacturer's instructions for storage, handling, and preparation instructions.

Primer and Probe Preparation:

- 1) Upon receipt, store dried primers and probes at 2-8°C.
- 2) Precautions: These reagents should only be handled in a clean area and stored at appropriate temperatures (see below) in the dark. Freeze-thaw cycles should be avoided. Maintain cold when thawed.
- 3) Using aseptic technique, suspend dried reagents in 1.5 mL of nuclease-free water and allow to rehydrate for 15 min at room temperature in the dark.
- 4) Mix gently and aliquot primers/probe in 300 µL volumes into 5 pre-labeled tubes. Store a single, working aliquot of primers/probes at 2-8°C in the dark. Store remaining aliquots at ≤ -20°C in a non-frost-free freezer. Do not refreeze thawed aliquots (stable for up to 4 months at 2-8°C).

2019-nCoV Positive Control (nCoVPC) Preparation:

- 1) Precautions: This reagent should be handled with caution in a dedicated nucleic acid handling area to prevent possible contamination. Freeze-thaw cycles should be avoided. Maintain on ice when thawed.
- 2) Resuspend dried reagent in each tube in 1 mL of nuclease-free water to achieve the proper concentration. Make single use aliquots (approximately 30 µL) and store at $\leq -70^{\circ}\text{C}$.
- 3) Thaw a single aliquot of diluted positive control for each experiment and hold on ice until adding to plate. Discard any unused portion of the aliquot.

Human Specimen Control (HSC) (not provided)

- 1) Human Specimen Control (HSC) or one of the listed acceptable alternative extraction controls must be extracted and processed with each specimen extraction run.
- 2) Refer to the Human Specimen Control (HSC) package insert for instructions for use.

No Template Control (NTC) (not provided)

- 1) Sterile, nuclease-free water
- 2) Aliquot in small volumes
- 3) Used to check for contamination during specimen extraction and/or plate set-up

General Preparation**Equipment Preparation**

Clean and decontaminate all work surfaces, pipettes, centrifuges, and other equipment prior to use. Decontamination agents should be used including 10% bleach, 70% ethanol, and DNAzap™, or RNase AWAY™ to minimize the risk of nucleic acid contamination.

Nucleic Acid Extraction

Performance of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel is dependent upon the amount and quality of template RNA purified from human specimens. The following commercially available RNA extraction kits and procedures have been qualified and validated for recovery and purity of RNA for use with the panel:

Qiagen QIAamp® DSP Viral RNA Mini Kit or QIAamp® Viral RNA Mini Kit

Recommendation(s): Utilize 100 µL of sample and elute with 100 µL of buffer or utilize 140 µL of sample and elute with 140 µL of buffer.

Qiagen EZ1 Advanced XL

Kit: Qiagen EZ1 DSP Virus Kit and Buffer AVL (supplied separately) for offboard lysis

Card: EZ1 Advanced XL DSP Virus Card

Recommendation(s): Add 120 µL of sample to 280 µL of pre-aliquoted Buffer AVL (total input sample volume is 400 µL). Proceed with the extraction on the EZ1 Advanced XL. Elution volume is 120 µL.

Kit: Qiagen EZ1 Virus Mini Kit v2.0 and Buffer AVL (supplied separately) for offboard lysis

Card: EZ1 Advanced XL Virus Card v2.0

Recommendation(s): Add 120 µL of sample to 280 µL of pre-aliquoted Buffer AVL (total input sample volume is 400 µL). Proceed with the extraction on the EZ1 Advanced XL. Elution volume is 120 µL.

Roche MagNA Pure 96

Kit: Roche MagNA Pure 96 DNA and Viral NA Small Volume Kit

Protocol: Viral NA Plasma Ext LysExt Lys SV 4.0 Protocol or Viral NA Plasma Ext Lys SV Protocol

Recommendation(s): Add 100 µL of sample to 350 µL of pre-aliquoted External Lysis Buffer (supplied separately) (total input sample volume is 450 µL). Proceed with the extraction on the MagNA Pure 96. **(Internal Control = None)**. Elution volume is 100 µL.

Roche MagNA Pure 24

Kit: Roche MagNA Pure 24 Total NA Isolation Kit

Protocol: Pathogen 1000 2.0 Protocol

Recommendation(s): Add 100 µL of sample to 400 µL of pre-aliquoted External Lysis Buffer (supplied separately) (total input sample volume is 500 µL). Proceed with the extraction on the MagNA Pure 24. **(Internal Control = None)**. Elution volume is 100 µL.

Promega Maxwell® RSC 48

Kit: Promega Maxwell® Viral Total Nucleic Acid Purification Kit

Protocol: Viral Total Nucleic Acid

Recommendation(s): Add 120 µL of sample to 330 µL of pre-aliquoted External Lysis Buffer (300 µL Lysis Buffer plus 30 µL Proteinase K; supplied within the kit) (total input volume is 450 µL). Proceed with the extraction on the Maxwell® RSC 48. Elution volume is 75 µL.

Equivalence and performance of the following extraction platforms were demonstrated with the CDC Human Influenza Virus Real-Time RT-PCR Diagnostic Panel (K190302) and based on those data are acceptable for use with the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel.

QIAGEN QIAcube

Kit: QIAGEN QIAamp® DSP Viral RNA Mini Kit or QIAamp® Viral RNA Mini Kit

Recommendations: Utilize 140 µL of sample and elute with 100 µL of buffer.

Roche MagNA Pure LC

Kit: Roche MagNA Pure Total Nucleic Acid Kit

Protocol: Total NA External_lysis

Recommendation(s): Add 100 µL of sample to 300 µL of pre-aliquoted TNA isolation kit lysis buffer (total input sample volume is 400 µL). Elution volume is 100 µL.

Roche MagNA Pure Compact

Kit: Roche MagNA Pure Nucleic Acid Isolation Kit I

Protocol: Total_NA_Plasma100_400

Recommendation(s): Add 100 µL of sample to 300 µL of pre-aliquoted TNA isolation kit lysis buffer (total input sample volume is 400 µL). Elution volume is 100 µL.

bioMérieux NucliSENS® easyMAG® Instrument

Protocol: General protocol (not for blood) using “Off-board Lysis” reagent settings.

Recommendation(s): Add 100 µL of sample to 1000 µL of pre-aliquoted easyMAG lysis buffer (total input sample volume is 1100 µL). Incubate for 10 minutes at room temperature. Elution volume is 100 µL.

bioMérieux EMAG® Instrument

Protocol: Custom protocol: **CDC Flu V1** using “Off-board Lysis” reagent settings.

Recommendation(s): Add 100 µL of samples to 2000 µL of pre-aliquoted easyMAG lysis buffer (total input sample volume is 2100 µL). Incubate for 10 minutes at room temperature. Elution volume is 100 µL. The custom protocol, **CDC Flu V1**, is programmed on the bioMérieux EMAG® instrument with the assistance of a bioMérieux service representative. Installation verification is documented at the time of installation. Laboratories are recommended to retain a record of the step-by-step verification of the bioMérieux custom protocol installation procedure.

Manufacturer’s recommended procedures (except as noted in recommendations above) are to be followed for sample extraction. HSC must be included in each extraction batch.

Disclaimer: Names of vendors or manufacturers are provided as examples of suitable product sources. Inclusion does not imply endorsement by the Centers for Disease Control and Prevention.

Assay Set Up**Reaction Master Mix and Plate Set Up**

Note: Plate set-up configuration can vary with the number of specimens and workday organization. NTCs and nCoVPCs must be included in each run.

- 1) In the reagent set-up room clean hood, place rRT-PCR buffer, enzyme, and primer/probes on ice or cold-block. Keep cold during preparation and use.
- 2) Mix buffer, enzyme, and primer/probes by inversion 5 times.
- 3) Centrifuge reagents and primers/probes for 5 seconds to collect contents at the bottom of the tube, and then place the tube in a cold rack.
- 4) Label one 1.5 mL microcentrifuge tube for each primer/probe set.
- 5) Determine the number of reactions (N) to set up per assay. It is necessary to make excess reaction mix for the NTC, nCoVPC, HSC (if included in the RT-PCR run), and RP reactions and for pipetting error. Use the following guide to determine N:
 - If number of samples (n) including controls equals 1 through 14, then $N = n + 1$
 - If number of samples (n) including controls is 15 or greater, then $N = n + 2$
- 7) For each primer/probe set, calculate the amount of each reagent to be added for each reaction mixture ($N = \#$ of reactions).

Thermofisher TaqPath™ 1-Step RT-qPCR Master Mix

Step #	Reagent	Vol. of Reagent Added per Reaction
1	Nuclease-free Water	N x 8.5 µL
2	Combined Primer/Probe Mix	N x 1.5 µL
3	TaqPath™ 1-Step RT-qPCR Master Mix (4x)	N x 5.0 µL
	Total Volume	N x 15.0 µL

Promega GoTaq® Probe 1- Step RT-qPCR System

Step #	Reagent	Vol. of Reagent Added per Reaction
1	Nuclease-free Water	N x 3.1 µL
2	Combined Primer/Probe Mix	N x 1.5 µL
3	GoTaq Probe qPCR Master Mix with dUTP	N x 10.0 µL
4	Go Script RT Mix for 1-Step RT-qPCR	N x 0.4 µL
	Total Volume	N x 15.0 µL

Quantabio qScript XLT One-Step RT-qPCR ToughMix

Step #	Reagent	Vol. of Reagent Added per Reaction
1	Nuclease-free Water	N x 3.5 µL
2	Combined Primer/Probe Mix	N x 1.5 µL
3	qScript XLT One-Step RT-qPCR ToughMix (2X)	N x 10.0 µL
	Total Volume	N x 15.0 µL

Quantabio UltraPlex 1-Step ToughMix (4X)

Step #	Reagent	Vol. of Reagent Added per Reaction
1	Nuclease-free Water	N x 8.5 µL
2	Combined Primer/Probe Mix	N x 1.5 µL
3	UltraPlex 1-Step ToughMix (4X)	N x 5.0 µL
	Total Volume	N x 15.0 µL

- 8) Dispense reagents into each respective labeled 1.5 mL microcentrifuge tube. After addition of the reagents, mix reaction mixtures by pipetting up and down. **Do not vortex.**
- 9) Centrifuge for 5 seconds to collect contents at the bottom of the tube, and then place the tube in a cold rack.
- 10) Set up reaction strip tubes or plates in a 96-well cooler rack.
- 11) Dispense 15 µL of each master mix into the appropriate wells going across the row as shown below (**Figure 1**):

Figure 1: Example of Reaction Master Mix Plate Set-Up

	1	2	3	4	5	6	7	8	9	10	11	12
A	N1	N1	N1	N1	N1	N1	N1	N1	N1	N1	N1	N1
B	N2	N2	N2	N2	N2	N2	N2	N2	N2	N2	N2	N2
C	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP	RP
D												
E												
F												
G												
H												

- 12) Prior to moving to the nucleic acid handling area, prepare the No Template Control (NTC) reactions for column #1 in the assay preparation area.
- 13) Pipette 5 µL of nuclease-free water into the NTC sample wells (**Figure 2**, column 1). Securely cap NTC wells before proceeding.
- 14) Cover the entire reaction plate and move the reaction plate to the specimen nucleic acid handling area.

Nucleic Acid Template Addition

- 1) Gently vortex nucleic acid sample tubes for approximately 5 seconds.
- 2) Centrifuge for 5 seconds to collect contents at the bottom of the tube.
- 3) After centrifugation, place extracted nucleic acid sample tubes in the cold rack.
- 4) Samples should be added to columns 2-11 (column 1 and 12 are for controls) to the specific assay that is being tested as illustrated in **Figure 2**. Carefully pipette 5.0 µL of the first sample into all the wells labeled for that sample (i.e. Sample "S1" down column #2). *Keep other sample wells covered during addition. Change tips after each addition.*
- 5) Securely cap the column to which the sample has been added to prevent cross contamination and to ensure sample tracking.
- 6) Change gloves often and when necessary to avoid contamination.
- 7) Repeat steps #4 and #5 for the remaining samples.

- 8) If necessary, add 5 µL of Human Specimen Control (HSC) extracted sample to the HSC wells (**Figure 2**, column 11). Securely cap wells after addition. NOTE: Per CLIA regulations, HSC must be tested at least once per day.
- 9) Cover the entire reaction plate and move the reaction plate to the positive template control handling area.

Assay Control Addition

- 1) Pipette 5 µL of nCoVPC RNA to the sample wells of column 12 (**Figure 2**). Securely cap wells after addition of the control RNA.
NOTE: If using 8-tube strips, label the TAB of each strip to indicate sample position. DO NOT LABEL THE TOPS OF THE REACTION TUBES!
- 2) Briefly centrifuge reaction tube strips for 10-15 seconds. After centrifugation return to cold rack.
NOTE: If using 96-well plates, centrifuge plates for 30 seconds at 500 x g, 4°C.

Figure 2. 2019-nCoV rRT-PCR Diagnostic Panel: Example of Sample and Control Set-up

	1	2	3	4	5	6	7	8	9	10	11 ^a	12
A	NTC	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	nCoV PC
B	NTC	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	nCoV PC
C	NTC	S1	S2	S3	S4	S5	S6	S7	S8	S9	S10	nCoV PC
D												
E												
F												
G												
H												

^aReplace the sample in this column with extracted HSC if necessary

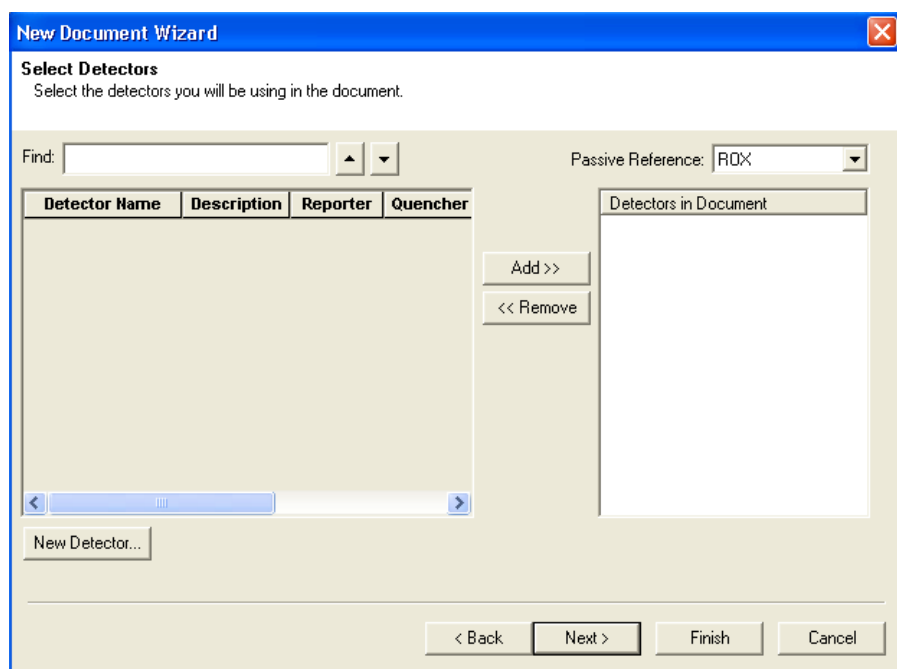
Create a Run Template on the Applied Biosystems 7500 Fast Dx Real-time PCR Instrument (Required if no template exists)

If the template already exists on your instrument, please proceed to the **RUNNING A TEST** section.

- 1) Launch the Applied Biosystems 7500 Fast Dx Real-time PCR Instrument by double clicking on the Applied Biosystems 7500 Fast Dx System icon on the desktop.
- 2) A new window should appear, select **Create New Document** from the menu.

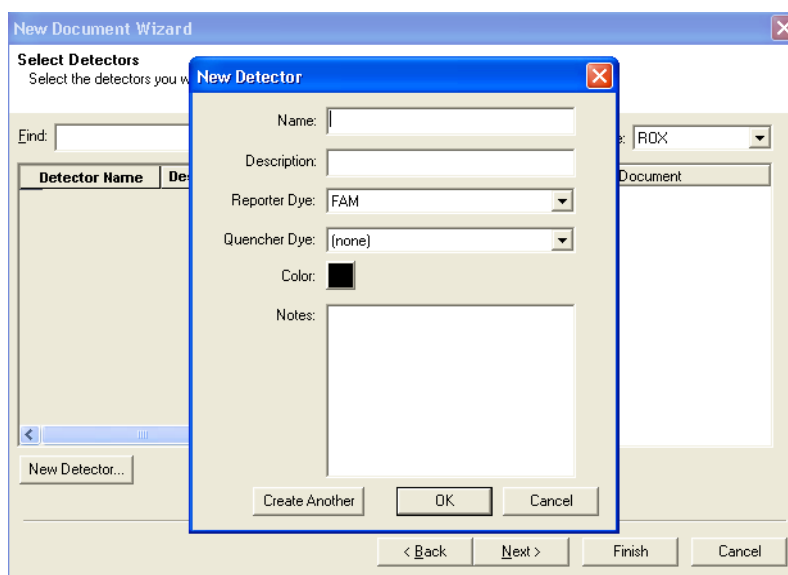
Figure 3. New Document Wizard Window

- 3) The **New Document Wizard** screen in **Figure 3** will appear. Select:
 - a. Assay: **Standard Curve (Absolute Quantitation)**
 - b. Container: **96-Well Clear**
 - c. Template: **Blank Document**
 - d. Run Mode: **Standard 7500**
 - e. Operator: **Your Name**
 - f. Comments: **SDS v1.4**
 - g. Plate Name: **Your Choice**
- 4) After making selections click **Next** at the bottom of the window.

Figure 4. Creating New Detectors

NOTE: ROX is the default passive reference. This will be changed to “none” in step 12.

- 5) After selecting next, the **Select Detectors** screen (**Figure 4**) will appear.
- 6) Click the **New Detector** button (see **Figure 4**).
- 7) The **New Detector** window will appear (**Figure 5**). A new detector will need to be defined for each primer and probe set. Creating these detectors will enable you to analyze each primer and probe set individually at the end of the reaction.

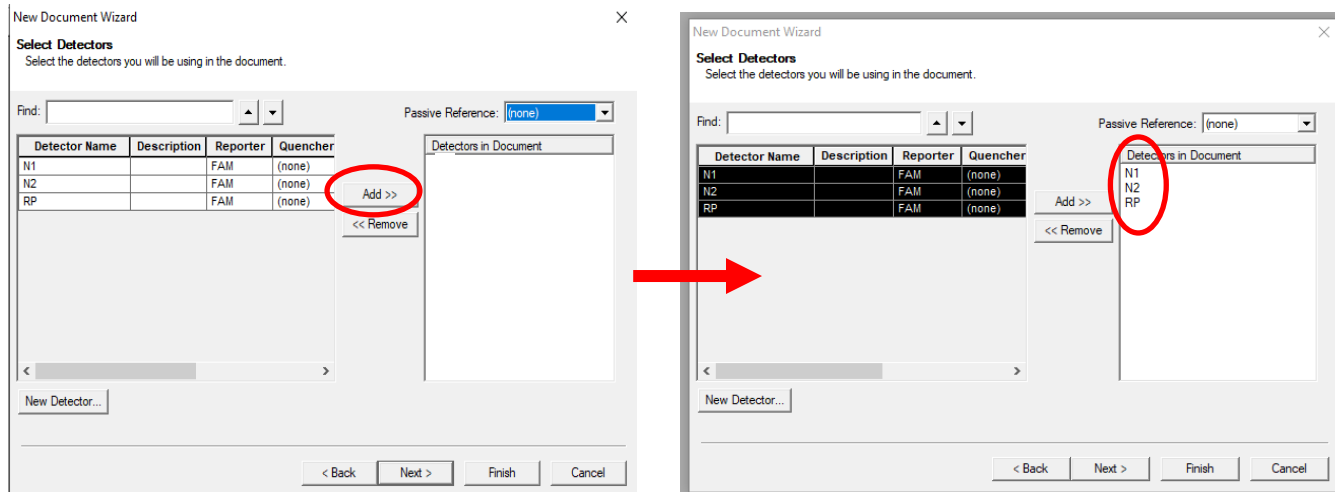
Figure 5. New Detector Window

- 8) Start by creating the N1 Detector. Include the following:
- Name: **N1**
 - Description: *leave blank*
 - Reporter Dye: **FAM**
 - Quencher Dye: **(none)**
 - Color: *to change the color of the detector indicator do the following:*
 - ⇒ Click on the color square to reveal the color chart
 - ⇒ Select a color by clicking on one of the squares
 - ⇒ After selecting a color click **OK** to return to the New Detector screen
 - Click the **OK** button of the New Detector screen to return to the screen shown in **Figure 4**.
- 9) Repeat step 6-8 for each target in the panel.

Name	Reporter Dye	Quencher Dye
N1	FAM	(none)
N2	FAM	(none)
RP	FAM	(none)

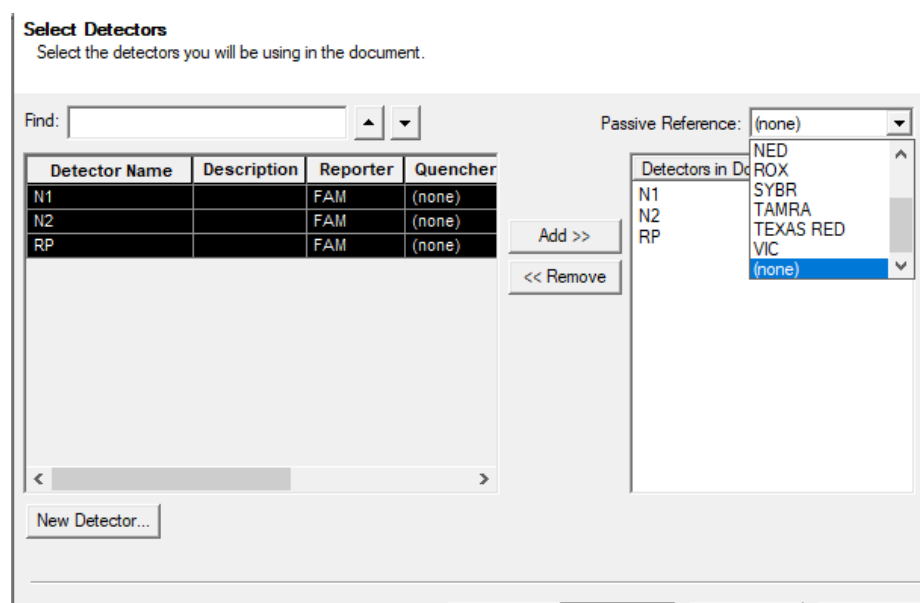
- 10) After each Detector is added, the **Detector Name**, **Description**, **Reporter** and **Quencher** fields will become populated in the **Select Detectors** screen (Figure 6).
- 11) Before proceeding, the newly created detectors must be added to the document. To add the new detectors to the document, click **ADD** (see Figure 6). Detector names will appear on the right-hand side of the **Select Detectors** window (Figure 6).

Figure 6. Adding New Detectors to Document



- 12) Once all detectors have been added, select **(none)** for **Passive Reference** at the top right-hand drop-down menu (Figure 7).

Figure 7. Select Passive Reference



Passive reference should be set to “(none)” as described above.

- 13) Click **Next** at the bottom of the **Select Detectors** window to proceed to the **Set Up Sample Plate** window (**Figure 8**).
- 14) In the **Set Up Sample Plate** window (**Figure 8**), use your mouse to select row A from the lower portion of the window, in the spreadsheet (see **Figure 8**).
- 15) In the top portion of the window, select detector **N1**. A check will appear next to the detector you have selected (**Figure 8**). You will also notice the row in the spreadsheet will be populated with a colored "U" icon to indicate which detector you've selected.
- 16) Repeat step 14-15 for each detector that will be used in the assay.

Figure 8. Sample Plate Set-up

New Document Wizard
Set Up Sample Plate
 Setup the sample plate with tasks, quantities and detectors.

Use	Detector	Reporter	Quencher	Task	Quantity
<input checked="" type="checkbox"/>	N1	FAM	(none)	Unknown	
<input type="checkbox"/>	N2	FAM	(none)	Unknown	
<input type="checkbox"/>	RP	FAM	(none)	Unknown	

	1	2	3	4	5	6	7	8	9	10	11	12
A	U	U	U	U	U	U	U	U	U	U	U	U
B												
C												
D												
E												
F												
G												
H												

< Back Next > Finish Cancel

- 17) Select **Finish** after detectors have been assigned to their respective rows. (**Figure 9**).

Figure 9. Finished Plate Set-up

New Document Wizard
Set Up Sample Plate
 Setup the sample plate with tasks, quantities and detectors.

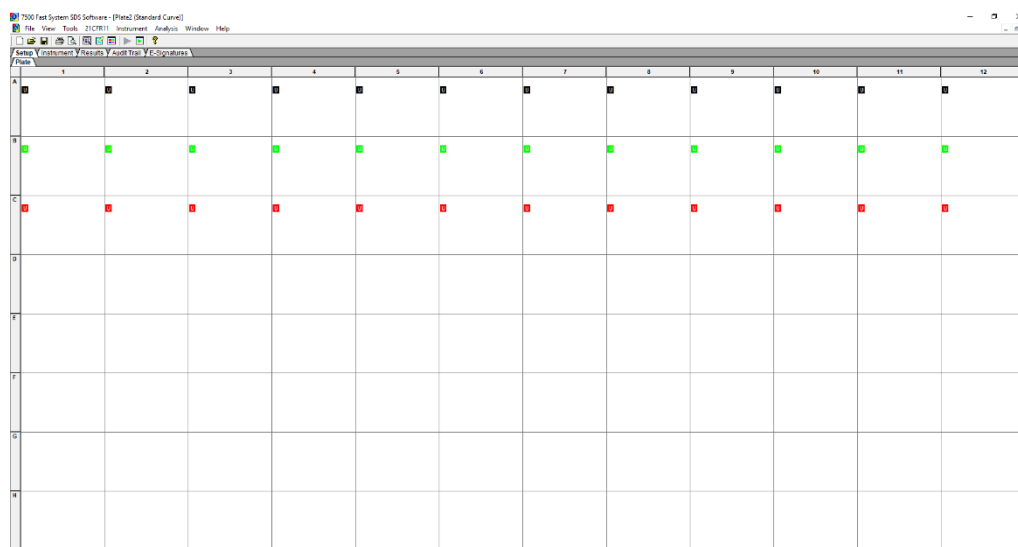
Use	Detector	Reporter	Quencher	Task	Quantity
<input type="checkbox"/>	N1	FAM	(none)	Unknown	
<input type="checkbox"/>	N2	FAM	(none)	Unknown	
<input checked="" type="checkbox"/>	RP	FAM	(none)	Unknown	

	1	2	3	4	5	6	7	8	9	10	11	12
A	U	U	U	U	U	U	U	U	U	U	U	U
B	U	U	U	U	U	U	U	U	U	U	U	U
C	U	U	U	U	U	U	U	U	U	U	U	U
D												
E												
F												
G												
H												

< Back Next > Finish Cancel

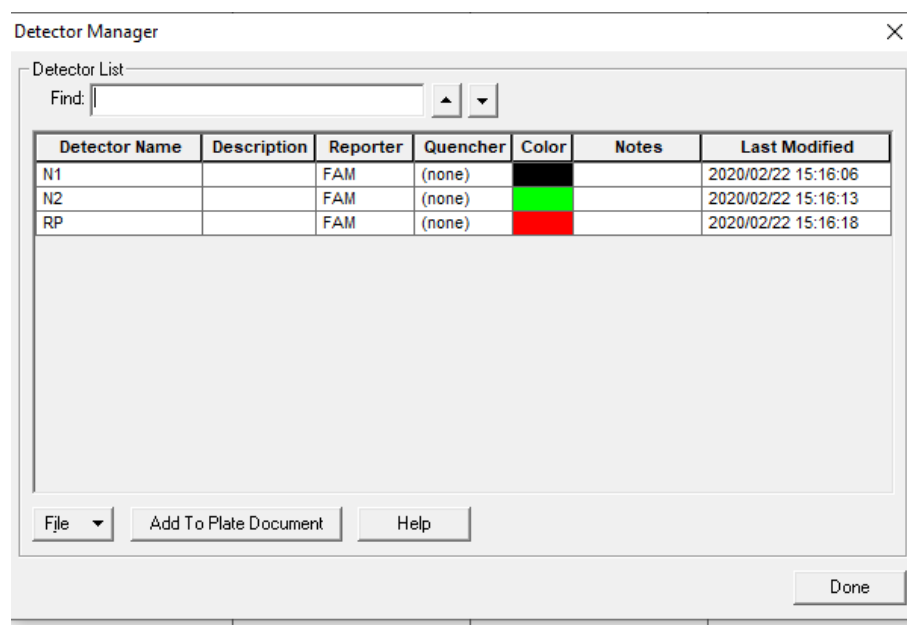
- 18) After clicking “Finish”, there will be a brief pause allowing the Applied Biosystems 7500 Fast Dx to initialize. This initialization is followed by a clicking noise. **Note: The machine must be turned on for initialization.**
- 19) After initialization, the **Plate** tab of the Setup (**Figure 10**) will appear.
- 20) Each well of the plate should contain colored U icons that correspond with the detector labels that were previously chosen. To confirm detector assignments, select **Tools** from the file menu, then select **Detector Manager**.

Figure 10. Plate Set-up Window



21) The Detector Manager window will appear (**Figure 11**).

Figure 11. Detector Manager Window



22) Confirm all detectors are included and that each target has a **Reporter** set to **FAM** and the **Quencher** is set to **(none)**.

23) If all detectors are present, select **Done**. The detector information has been created and assigned to wells on the plate.

Defining the Instrument Settings

- 1) After detectors have been created and assigned, proceed to instrument set up.
- 2) Select the **Instrument** tab to define thermal cycling conditions.
- 3) Modify the thermal cycling conditions as follows (**Figure 12**):

Thermofisher TaqPath™ 1-Step RT-qPCR Master Mix, CG

- a. In Stage 1, Set to 2 min at **25°C**; **1 Rep**.
- b. In Stage 2, Set to 15 min at **50°C**; **1 Rep**.
- c. In Stage 3, Set to 2 min at **95°C**, **1 Rep**.
- d. In Stage 4, Step 1 set to **3 sec** at **95°C**.
- e. In Stage 4, Step 2 set to **30 sec** at **55.0°C**.
- f. In Stage 4, Reps should be set to **45**.
- g. Under **Settings** (**Figure 12**), bottom left-hand box, change volume to 20 µL.
- h. Under **Settings**, **Run Mode** selection should be **Standard 7500**.
- i. Step 2 of Stage 4 should be highlighted in yellow to indicate data collection (see **Figure 12**).

OR

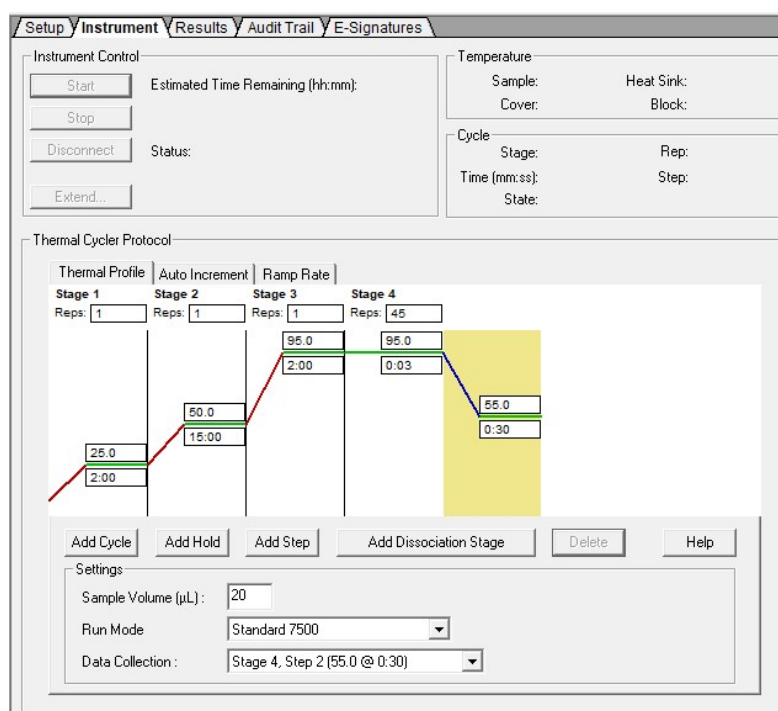
Quantabio qScript™ XLT One-Step RT-qPCR ToughMix or UltraPlex 1-Step ToughMix (4X)

- a. In Stage 1, Set to 10 min at **50°C; 1 Rep.**
- b. In Stage 2, Set to 3 min at **95°C, 1 Rep.**
- c. In Stage 3, Step 1 set to **3 sec** at **95°C.**
- d. In Stage 3, Step 2 set to **30 sec** at **55.0°C.**
- e. In Stage 3, Reps should be set to **45.**
- f. Under **Settings (Figure 12)**, bottom left-hand box, change volume to 20 µL.
- g. Under **Settings, Run Mode** selection should be **Standard 7500.**
- h. Step 2 of Stage 3 should be highlighted in yellow to indicate data collection (see **Figure 12**).

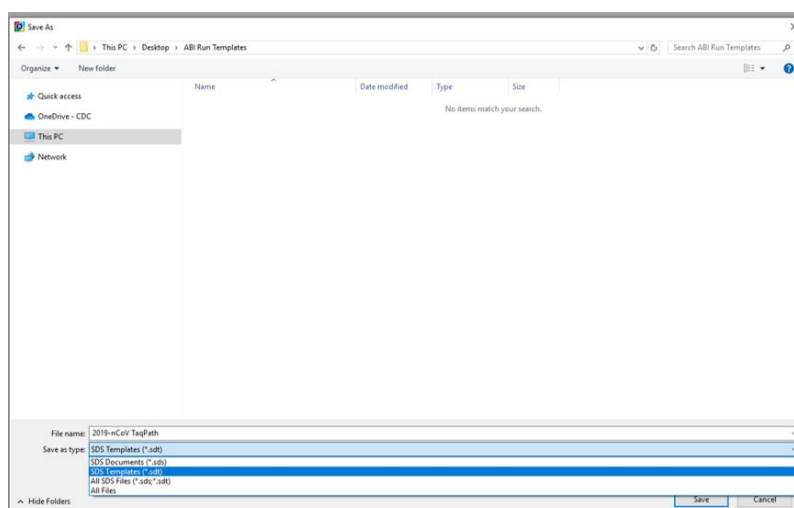
OR

Promega GoTaq® Probe 1-Step RT-qPCR System

- a. In Stage 1, Set to 15 min at **45°C; 1 Rep.**
- b. In Stage 2, Set to 2 min at **95°C, 1 Rep.**
- c. In Stage 3, Step 1 set to **3 sec** at **95°C.**
- d. In Stage 3, Step 2 set to **30 sec** at **55.0°C.**
- e. In Stage 3, Reps should be set to **45.**
- f. Under **Settings (Figure 12)**, bottom left-hand box, change volume to 20 µL.
- g. Under **Settings, Run Mode** selection should be **Standard 7500.**
- h. Step 2 of Stage 3 should be highlighted in yellow to indicate data collection (see **Figure 12**).

Figure 12. Instrument Window

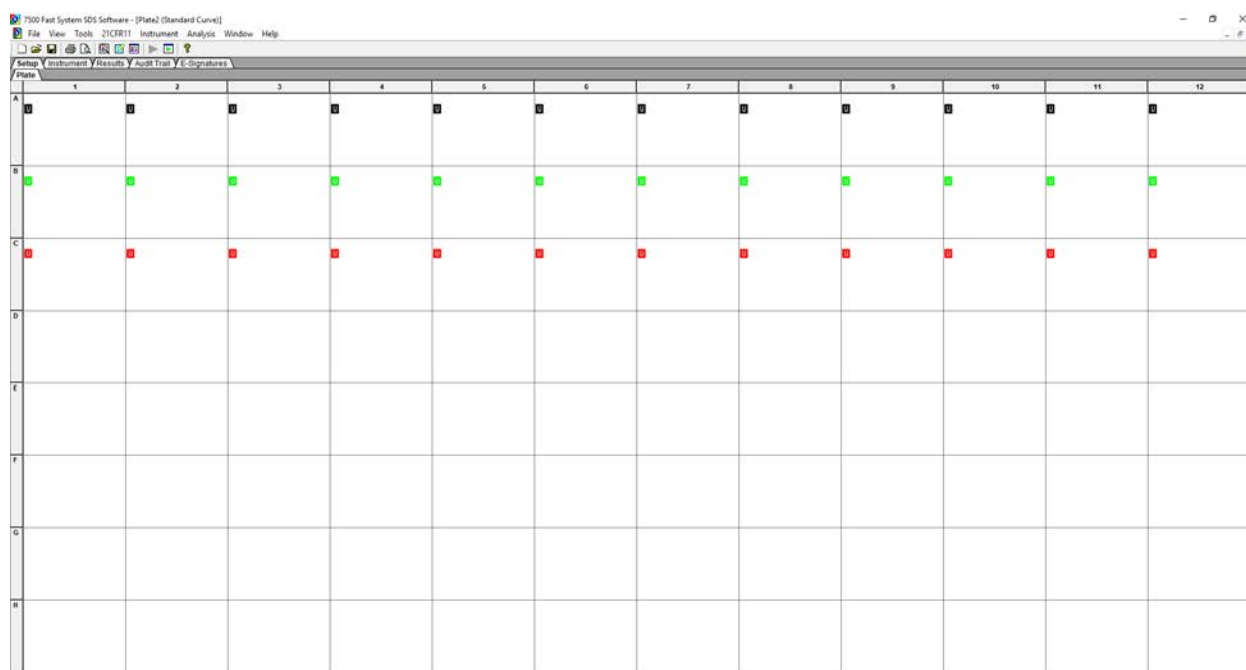
- 4) After making changes to the **Instrument** tab, the template file is ready to be saved. To save the template, select **File** from the top menu, then select **Save As**. Since the enzyme options have different instrument settings, it is recommended that the template be saved with a name indicating the enzyme option.
- 5) Save the template as **2019-nCoV Dx Panel TaqPath** or **2019-nCoV Dx Panel Quanta** or **2019-nCoV Dx Panel Promega** as appropriate in the desktop folder labeled **"ABI Run Templates"** (you must create this folder). Save as type should be SDS Templates (*.sdt) (**Figure 13**).

Figure 13. Saving Template

Running a Test

- 1) Turn on the ABI 7500 Fast Dx Real-Time PCR Instrument.
- 2) Launch the Applied Biosystems 7500 Fast Dx Real-time PCR System by double clicking on the 7500 Fast Dx System icon on the desktop.
- 3) A new window should appear, select **Open Existing Document** from the menu.
- 4) Navigate to select your ABI Run Template folder from the desktop.
- 5) Double click on the appropriate template file (**2019-nCoV Dx Panel TaqPath** or **2019-nCoV Dx Panel Quanta** or **2019-nCoV Dx Panel Promega**)
- 6) There will be a brief pause allowing the Applied Biosystems 7500 Fast Dx Real-Time PCR Instrument to initialize. This initialization is followed by a clicking noise. **Note: The machine must be turned on for initialization.**

Figure 14. Plate Set-up Window



- 7) After the instrument initializes, a plate map will appear (**Figure 14**). The detectors and controls should already be labeled as they were assigned in the original template.


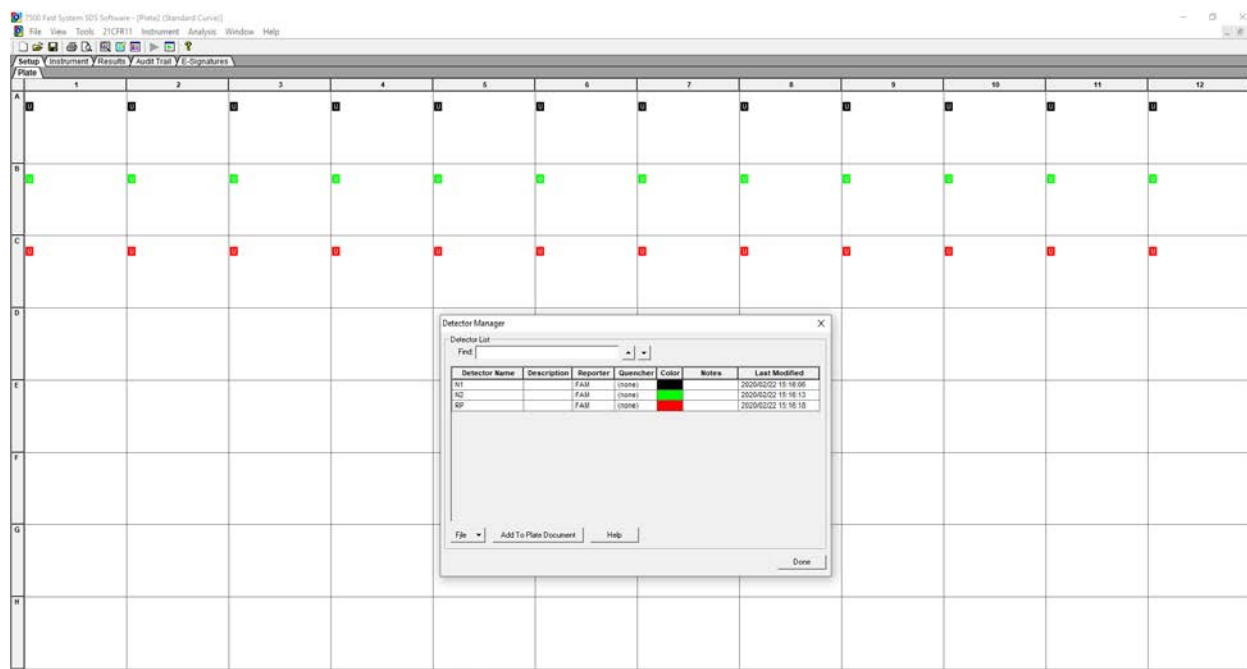
- 8) Click the **Well Inspector** icon  from the top menu.
- 9) Highlight specimen wells of interest on the plate map.
- 10) Type sample identifiers to **Sample Name** box in the **Well Inspector** window (**Figure 15**).

Figure 15. Labeling Wells



- 11) Repeat steps 9-10 until all sample identifiers are added to the plate setup.

- 12) Once all specimen and control identifiers are added click the **Close** button on the **Well Inspector** window to return to the **Plate** set up tab.
- 13) Click the **Instrument** tab at the upper left corner.
- 14) The reaction conditions, volumes, and type of 7500 reaction should already be loaded (**Figure 16**).

Figure 16. Instrument Settings

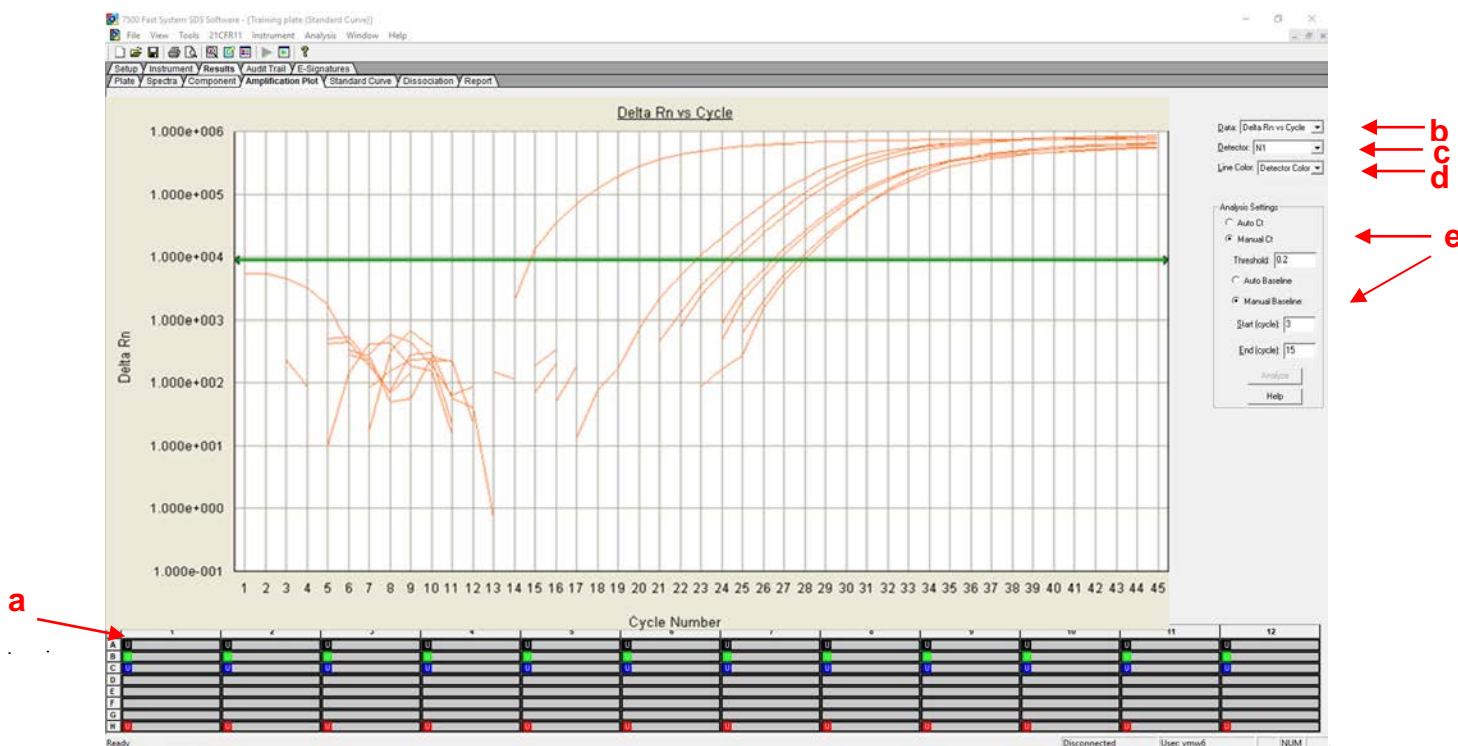
The screenshot displays the 'Instrument' tab of a software interface. At the top, there are five tabs: 'Setup', 'Instrument' (selected), 'Results', 'Audit Trail', and 'E-Signatures'. Below the tabs, the 'Instrument Control' section contains buttons for 'Start', 'Stop', 'Disconnect', and 'Extend...', along with 'Estimated Time Remaining (hh:mm):' and 'Status:' labels. To the right, the 'Temperature' section has 'Sample:' and 'Cover:' labels, and the 'Heat Sink:' and 'Block:' labels. Below that, the 'Cycle' section has 'Stage:', 'Rep:', 'Time (mm:ss):', and 'State:' labels. The main area is the 'Thermal Cycler Protocol' section, which includes a 'Thermal Profile' tab, 'Auto Increment', and 'Ramp Rate' options. The profile is divided into four stages: Stage 1 (Reps: 1, 25.0, 2:00), Stage 2 (Reps: 1, 50.0, 15:00), Stage 3 (Reps: 1, 95.0, 2:00), and Stage 4 (Reps: 45, 95.0, 0:03). A graph shows the temperature profile with a red line for the first three stages and a blue line for the fourth stage. Below the graph are buttons for 'Add Cycle', 'Add Hold', 'Add Step', 'Add Dissociation Stage', 'Delete', and 'Help'. At the bottom, the 'Settings' section includes 'Sample Volume (µL):' (20), 'Run Mode:' (Standard 7500), and 'Data Collection:' (Stage 4, Step 2 (55.0 @ 0:30)).

- 15) Ensure settings are correct (refer to the *Defining Instrument Settings*).
- 16) Before proceeding, the run file must be saved; from the main menu, select **File**, then **Save As**. Save in appropriate run folder designation.
- 17) Load the plate into the plate holder in the instrument. Ensure that the plate is properly aligned in the holder.
- 18) Once the run file is saved, click the **Start** button. *Note: The run should take approximately 1 hour and 20 minutes to complete.*

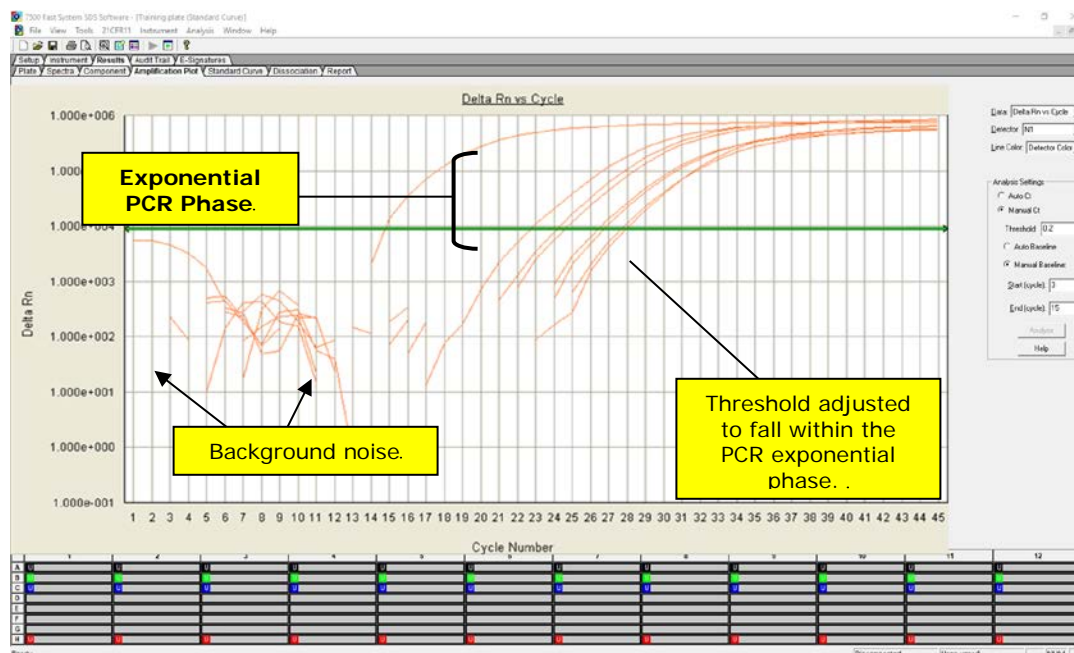
Data Analysis

- 1) After the run has completed, select the **Results** tab at the upper left corner of the software.
- 2) Select the **Amplification Plot** tab to view the raw data (**Figure 17**).

Figure 17. Amplification Plot Window



- 3) Start by highlighting all the samples from the run; to do this, click on the upper left-hand box (a) of the sample wells (**Figure 17**). All the growth curves should appear on the graph.
- 4) On the right-hand side of the window (b), the **Data** drop down selection should be set to **Delta Rn vs. Cycle**.
- 5) Select **N1** from (c), the **Detector** drop down menu, using the downward arrow.
 - a. Please note that each detector is analyzed individually to reflect different performance profiles of each primer and probe set.
- 6) In the **Line Color** drop down (d), **Detector Color** should be selected.
- 7) Under **Analysis Settings** select **Manual Ct** (e).
 - b. Do not change the **Manual Baseline** default numbers.
- 8) Using the mouse, click and drag the red threshold line until it lies within the exponential phase of the fluorescence curves and above any background signal (**Figure 18**).

Figure 18. Amplification Plot

- 9) Click the **Analyze** button in the lower right corner of the window. The red threshold line will turn to green, indicating the data has been analyzed.
- 10) Repeat steps 5-9 to analyze results generated for each set of markers (N1, N2, RP).
- 11) Save analysis file by selecting **File** then **Save As** from the main menu.
- 12) After completing analysis for each of the markers, select the **Report** tab above the graph to display the Ct values (**Figure 19**). To filter report by sample name in ascending or descending order, simply click on **Sample Name** in the table.

Figure 19. Report

7500 Fast System SDS Software - (Post-Run nCoVPC Lot 20-0121_275030252_R1Made (Standard Curve))

File View Tools ZICR011 Instrument Analysis Window Help

Setup Y Instrument Y Results Y Amplification Plot Y Standard Curve Y Dissociation Y Report

Well	Sample Name	Detector	Task	Ct	StdDev Ct	Quantity	Mean Qty	StdDev Qty	Filtered	Em
A1	NTC	N1	Unknown	Undet						
A2	ncgVRC 1	N1	Unknown	20.2502						
A3	ncgVRC 2	N1	Unknown	20.8418						
A4	ncgVRC 3	N1	Unknown	20.4563						
A5	APC	N1	Unknown	25.4229						
B1	NTC	N2	Unknown	Undet						
B2	ncgVRC 1	N2	Unknown	20.6161						
B3	ncgVRC 2	N2	Unknown	21.6637						
B4	ncgVRC 3	N2	Unknown	21.2075						
B5	APC	N2	Unknown	26.440						
C1	NTC	RP	Unknown	Undet						
C2	ncgVRC 1	RP	Unknown	20.9188						
C3	ncgVRC 2	RP	Unknown	21.5667						
C4	ncgVRC 3	RP	Unknown	20.7028						
C5	APC	RP	Unknown	25.9688						

Interpretation of Results and Reporting

Extraction and Positive Control Results and Interpretation

No Template Control (NTC)

The NTC consists of using nuclease-free water in the rRT-PCR reactions instead of RNA. The NTC reactions for all primer and probe sets should not exhibit fluorescence growth curves that cross the threshold line. If any of the NTC reactions exhibit a growth curve that crosses the cycle threshold, sample contamination may have occurred. Invalidate the run and repeat the assay with strict adherence to the guidelines.

2019-nCoV Positive Control (nCoVPC)

The nCoVPC consists of in vitro transcribed RNA. The nCoVPC will yield a positive result with the following primer and probe sets: N1, N2, and RP.

Human Specimen Control (HSC) (Extraction Control)

When HSC is run with the CDC 2019-nCoV rRT-PCR Diagnostic Panel (see previous section on Assay Set Up), the HSC is used as an nucleic acid extraction procedural control to demonstrate successful recovery of nucleic acid as well as extraction reagent integrity. The HSC control consists of noninfectious cultured human cell (A549) material. Purified nucleic acid from the HSC should yield a positive result with the RP primer and probe set and negative results with all 2019-nCoV markers.

Expected Performance of Controls Included in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel

Control Type	External Control Name	Used to Monitor	2019 nCoV_N1	2019 nCoV_N2	RP	Expected Ct Values
Positive	nCoVPC	Substantial reagent failure including primer and probe integrity	+	+	+	< 40.00 Ct
Negative	NTC	Reagent and/or environmental contamination	-	-	-	None detected
Extraction	HSC	Failure in lysis and extraction procedure, potential contamination during extraction	-	-	+	< 40.00 Ct

If any of the above controls do not exhibit the expected performance as described, the assay may have been set up and/or executed improperly, or reagent or equipment malfunction could have occurred. Invalidate the run and re-test.

RNase P (Extraction Control)

- All clinical samples should exhibit fluorescence growth curves in the RNase P reaction that cross the threshold line within 40.00 cycles (< 40.00 Ct), thus indicating the presence of the human RNase P gene. Failure to detect RNase P in any clinical specimens may indicate:
 - Improper extraction of nucleic acid from clinical materials resulting in loss of RNA and/or RNA degradation.
 - Absence of sufficient human cellular material due to poor collection or loss of specimen integrity.
 - Improper assay set up and execution.
 - Reagent or equipment malfunction.
- If the RP assay does not produce a positive result for human clinical specimens, interpret as follows:
 - If the 2019-nCoV N1 and N2 are positive even in the absence of a positive RP, the result should be considered valid. It is possible, that some samples may fail to exhibit RNase P growth curves due to low cell numbers in the original clinical sample. A negative RP signal does not preclude the presence of 2019-nCoV virus RNA in a clinical specimen.
 - If all 2019-nCoV markers AND RNase P are negative for the specimen, the result should be considered invalid for the specimen. If residual specimen is available, repeat the extraction procedure and repeat the test. If all markers remain negative after re-test, report the results as invalid and a new specimen should be collected if possible.

2019-nCoV Markers (N1 and N2)

- When all controls exhibit the expected performance, a specimen is considered negative if all 2019-nCoV marker (N1, N2) cycle threshold growth curves DO NOT cross the threshold line within 40.00 cycles (< 40.00 Ct) AND the RNase P growth curve DOES cross the threshold line within 40.00 cycles (< 40.00 Ct).
- When all controls exhibit the expected performance, a specimen is considered positive for 2019-nCoV if all 2019-nCoV marker (N1, N2) cycle threshold growth curves cross the threshold line within 40.00 cycles (< 40.00 Ct). The RNase P may or may not be positive as described above, but the 2019-nCoV result is still valid.
- When all controls exhibit the expected performance and the growth curves for the 2019-nCoV markers (N1, N2) AND the RNase P marker DO NOT cross the cycle threshold growth curve within 40.00 cycles (< 40.00 Ct), the result is invalid. The extracted RNA from the specimen should be re-tested. If residual RNA is not available, re-extract RNA from residual specimen and re-test. If the re-tested sample is negative for all markers and RNase P, the result is invalid and collection of a new specimen from the patient should be considered.
- When all controls exhibit the expected performance and the cycle threshold growth curve for any one marker (N1 or N2, but not both markers) crosses the threshold line within 40.00 cycles (< 40.00 Ct) the result is inconclusive. The extracted RNA should be retested. If residual RNA is not available, re-extract RNA from residual specimen and re-test. If the same result is obtained,

report the inconclusive result. Consult with your state public health laboratory or CDC, as appropriate, to request guidance and/or to coordinate transfer of the specimen for additional analysis.

- If HSC is positive for N1 or N2, then contamination may have occurred during extraction or sample processing. Invalidate all results for specimens extracted alongside the HSC. Re-extract specimens and HSC and re-test.

2019-nCoV rRT-PCR Diagnostic Panel Results Interpretation Guide

The table below lists the expected results for the 2019-nCoV rRT-PCR Diagnostic Panel. If a laboratory obtains unexpected results for assay controls or if inconclusive or invalid results are obtained and cannot be resolved through the recommended re-testing, please contact CDC for consultation and possible specimen referral. See pages 13 and 50 for referral and contact information.

2019 nCoV_N1	2019 nCoV_N2	RP	Result Interpretation ^a	Report	Actions
+	+	±	2019-nCoV detected	Positive 2019-nCoV	Report results to CDC and sender.
If only one of the two targets is positive		±	Inconclusive Result	Inconclusive	Repeat testing of nucleic acid and/or re-extract and repeat rRT-PCR. If the repeated result remains inconclusive, contact your State Public Health Laboratory or CDC for instructions for transfer of the specimen or further guidance.
-	-	+	2019-nCoV not detected	Not Detected	Report results to sender. Consider testing for other respiratory viruses. ^b
-	-	-	Invalid Result	Invalid	Repeat extraction and rRT-PCR. If the repeated result remains invalid, consider collecting a new specimen from the patient.

^aLaboratories should report their diagnostic result as appropriate and in compliance with their specific reporting system.

^bOptimum specimen types and timing for peak viral levels during infections caused by 2019-nCoV have not been determined. Collection of multiple specimens from the same patient may be necessary to detect the virus. The possibility of a false negative result should especially be considered if the patient's recent exposures or clinical presentation suggest that 2019-nCoV infection is possible, and diagnostic tests for other causes of illness (e.g., other respiratory illness) are negative. If 2019-nCoV infection is still suspected, re-testing should be considered in consultation with public health authorities.

Quality Control

- Quality control requirements must be performed in conformance with local, state, and federal regulations or accreditation requirements and the user's laboratory's standard quality control procedures. For further guidance on appropriate quality control practices, refer to 42 CFR 493.1256.
- Quality control procedures are intended to monitor reagent and assay performance.
- Test all positive controls prior to running diagnostic samples with each new kit lot to ensure all reagents and kit components are working properly.
- Good laboratory practice (cGLP) recommends including a positive extraction control in each nucleic acid isolation batch.
- Although HSC is not included with the 2019-nCoV rRT-PCR Diagnostic Panel, the HSC extraction control must proceed through nucleic acid isolation per batch of specimens to be tested.
- Always include a negative template control (NTC) and the appropriate positive control (nCoVPC) in each amplification and detection run. All clinical samples should be tested for human RNase P gene to control for specimen quality and extraction.

Limitations

- All users, analysts, and any person reporting diagnostic results should be trained to perform this procedure by a competent instructor. They should demonstrate their ability to perform the test and interpret the results prior to performing the assay independently.
- Performance of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel has only been established in upper and lower respiratory specimens (such as nasopharyngeal or oropharyngeal swabs, sputum, lower respiratory tract aspirates, bronchoalveolar lavage, and nasopharyngeal wash/aspirate or nasal aspirate).
- Negative results do not preclude 2019-nCoV infection and should not be used as the sole basis for treatment or other patient management decisions. Optimum specimen types and timing for peak viral levels during infections caused by 2019-nCoV have not been determined. Collection of multiple specimens (types and time points) from the same patient may be necessary to detect the virus.
- A false-negative result may occur if a specimen is improperly collected, transported or handled. False-negative results may also occur if amplification inhibitors are present in the specimen or if inadequate numbers of organisms are present in the specimen.
- Positive and negative predictive values are highly dependent on prevalence. False-negative test results are more likely when prevalence of disease is high. False-positive test results are more likely when prevalence is moderate to low.
- Do not use any reagent past the expiration date.
- If the virus mutates in the rRT-PCR target region, 2019-nCoV may not be detected or may be detected less predictably. Inhibitors or other types of interference may produce a false-negative result. An interference study evaluating the effect of common cold medications was not performed.
- Test performance can be affected because the epidemiology and clinical spectrum of infection caused by 2019-nCoV is not fully known. For example, clinicians and laboratories may not know

the optimum types of specimens to collect, and, during the course of infection, when these specimens are most likely to contain levels of viral RNA that can be readily detected.

- Detection of viral RNA may not indicate the presence of infectious virus or that 2019-nCoV is the causative agent for clinical symptoms.
- The performance of this test has not been established for monitoring treatment of 2019-nCoV infection.
- The performance of this test has not been established for screening of blood or blood products for the presence of 2019-nCoV.
- This test cannot rule out diseases caused by other bacterial or viral pathogens.

Conditions of Authorization for the Laboratory

The CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Letter of Authorization, along with the authorized Fact Sheet for Healthcare Providers, the authorized Fact Sheet for Patients, and authorized labeling are available on the FDA website:

<https://www.fda.gov/MedicalDevices/Safety/EmergencySituations/ucm161496.htm>

Use of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel must follow the procedures outlined in these manufacturer's Instructions for Use and the conditions of authorization outlined in the Letter of Authorization. Deviations from the procedures outlined are not permitted under the Emergency Use Authorization (EUA). To assist clinical laboratories running the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel, the relevant Conditions of Authorization are listed verbatim below, and are required to be met by laboratories performing the EUA test.

- Authorized laboratories¹ will include with reports of the results of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel, all authorized Fact Sheets. Under exigent circumstances, other appropriate methods for disseminating these Fact Sheets may be used, which may include mass media.
- Authorized laboratories will perform the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel as outlined in the CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel Instructions for Use. Deviations from the authorized procedures, including the authorized RT-PCR instruments, authorized extraction methods, authorized clinical specimen types, authorized control materials, authorized other ancillary reagents and authorized materials required to perform the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel are not permitted.²
- Authorized laboratories that receive the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel must notify the relevant public health authorities of their intent to run the test prior to initiating testing.

¹Authorized Laboratories: For ease of reference, the Letter of Authorization refers to "laboratories certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 U.S.C. § 263a, to perform high complexity tests" as "authorized laboratories."

²If an authorized laboratory is interested in implementing changes to the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel that are not in the scope (Section II) of this letter of authorization FDA recommends you discuss with FDA after considering the policy outlined in *Immediately in Effect Guidance for Clinical Laboratories and Food and Drug Administration Staff: Policy for Diagnostics Testing in Laboratories Certified to Perform High Complexity Testing under CLIA prior to Emergency Use Authorization for Coronavirus Disease-2019 during the Public Health Emergency* (<https://www.fda.gov/media/135659/download>).

- Authorized laboratories will have a process in place for reporting test results to healthcare providers and relevant public health authorities, as appropriate.
- Authorized laboratories will collect information on the performance of the test and report to DMD/OHT7-OIR/OPEQ/CDRH (via email: CDRH-EUA-Reporting@fda.hhs.gov) and CDC (respvirus@cdc.gov) any suspected occurrence of false-positive or false-negative results and significant deviations from the established performance characteristics of the test of which they become aware.
- Authorized laboratories will report adverse events, including problems with test performance or results, to MedWatch by submitting the online FDA Form 3500 (<https://www.accessdata.fda.gov/scripts/medwatch/index.cfm?action=reporting.home>) or by calling 1-800-FDA-1088
- All laboratory personnel using the test must be appropriately trained in RT-PCR techniques and use appropriate laboratory and personal protective equipment when handling this kit and use the test in accordance with the authorized labeling.
- CDC, IRR, manufacturers and distributors of commercial materials identified as acceptable on the CDC website, and authorized laboratories will ensure that any records associated with this EUA are maintained until otherwise notified by FDA. Such records will be made available to FDA for inspection upon request.

Performance Characteristics

Analytical Performance:

Limit of Detection (LoD):

LoD studies determine the lowest detectable concentration of 2019-nCoV at which approximately 95% of all (true positive) replicates test positive. The LoD was determined by limiting dilution studies using characterized samples.

The analytical sensitivity of the rRT-PCR assays contained in the CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel were determined in Limit of Detection studies. Since no quantified virus isolates of the 2019-nCoV are currently available, assays designed for detection of the 2019-nCoV RNA were tested with characterized stocks of in vitro transcribed full length RNA (N gene; GenBank accession: MN908947.2) of known titer (RNA copies/ μ L) spiked into a diluent consisting of a suspension of human A549 cells and viral transport medium (VTM) to mimic clinical specimen. Samples were extracted using the QIAGEN EZ1 Advanced XL instrument and EZ1 DSP Virus Kit (Cat# 62724) and manually with the QIAGEN DSP Viral RNA Mini Kit (Cat# 61904). Real-Time RT-PCR assays were performed using the ThermoFisher Scientific TaqPath™ 1-Step RT-qPCR Master Mix, CG (Cat# A15299) on the Applied Biosystems™ 7500 Fast Dx Real-Time PCR Instrument according to the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel instructions for use.

A preliminary LoD for each assay was determined testing triplicate samples of RNA purified using each extraction method. The approximate LoD was identified by extracting and testing 10-fold serial dilutions of characterized stocks of in vitro transcribed full-length RNA. A confirmation of the LoD was determined using 3-fold serial dilution RNA samples with 20 extracted replicates. The LoD was determined as the lowest concentration where $\geq 95\%$ (19/20) of the replicates were positive.

Table 4. Limit of Detection Confirmation of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel with QIAGEN EZ1 DSP

Targets	2019-nCoV_N1			2019-nCoV_N2		
RNA Concentration ¹	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}
Positives/Total	20/20	19/20	13/20	20/20	17/20	9/20
Mean Ct ²	32.5	35.4	NA	35.8	NA	NA
Standard Deviation (Ct)	0.5	0.8	NA	1.3	NA	NA

¹ Concentration is presented in RNA copies/ μ L

² Mean Ct reported for dilutions that are $\geq 95\%$ positive. Calculations only include positive results.

NA not applicable

Table 5. Limit of Detection Confirmation CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel with QIAGEN QIAmp DSP Viral RNA Mini Kit

Targets	2019-nCoV_N1			2019-nCoV_N2			
RNA Concentration ¹	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}	10 ^{-1.0}
Positives/Total	20/20	20/20	6/20	20/20	20/20	20/20	8/20
Mean Ct ²	32.0	32.8	NA	33.0	35.4	36.2	NA
Standard Deviation (Ct)	0.7	0.8	NA	1.4	0.9	1.9	NA

¹ Concentration is presented in RNA copies/ μ L

² Mean Ct reported for dilutions that are $\geq 95\%$ positive. Calculations only include positive results.

NA not applicable

Table 6. Limit of Detection of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel

Virus	Material	Limit of Detection (RNA copies/ μ L)	
		QIAGEN EZ1 Advanced XL	QIAGEN DSP Viral RNA Mini Kit
2019 Novel Coronavirus	N Gene RNA Transcript	10 ^{0.5}	10 ⁰

FDA Sensitivity Evaluation: The analytical sensitivity of the test will be further assessed by evaluating an FDA-recommended reference material using an FDA developed protocol if applicable and/or when available.

In Silico Analysis of Primer and Probe Sequences:

The oligonucleotide primer and probe sequences of the CDC 2019 nCoV Real-Time RT-PCR Diagnostic Panel were evaluated against 31,623 sequences available in the Global Initiative on Sharing All Influenza Data (GISAID, <https://www.gisaid.org>) database as of June 20, 2020, to demonstrate the predicted inclusivity of the 2019-nCoV Real-Time RT-PCR Diagnostic Panel. Nucleotide mismatches in the primer/probe regions with frequencies > 0.1% are shown below. With the exception of one nucleotide mismatch with frequency > 1% (2.00%) at the third position of the N1 probe, the frequency of all mismatches was < 1%, indicating that prevalence of the mismatches were sporadic. Only one sequence (0.0032%) had two nucleotide mismatches in the N1 probe, and one other sequence from a different isolate (0.0032%) had two nucleotide mismatches in the N1 reverse primer. No sequences were found to have more than one mismatch in any N2 primer/probe region. The risk of these mismatches resulting in a significant loss in reactivity causing a false negative result is extremely low due to the design of the primers and probes, with melting temperatures > 60°C and with annealing temperature at 55°C that can tolerate up to two mismatches.

Table 7. In Silico Inclusivity Analysis of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Among 31,623 Genome Sequences Available from GISAID as of June 20, 2020

Primer/probe	N1 probe	N1 reverse		N2 probe
Location (5'>3')	3	15	21	13
Mismatch Nucleotide	C>T	G>T	T>C	C>T
Mismatch No.	632	34	71	46
Mismatch Frequency (%)	2.00	0.11	0.22	0.15

Specificity/Exclusivity Testing: In Silico Analysis

BLASTn analysis queries of the 2019-nCoV rRT-PCR assays primers and probes were performed against public domain nucleotide sequences. The database search parameters were as follows: 1) The nucleotide collection consists of GenBank+EMBL+DDBJ+PDB+RefSeq sequences, but excludes EST, STS, GSS, WGS, TSA, patent sequences as well as phase 0, 1, and 2 HTGS sequences and sequences longer than 100Mb; 2) The database is non-redundant. Identical sequences have been merged into one entry, while preserving the accession, GI, title and taxonomy information for each entry; 3) Database was updated on 10/03/2019; 4) The search parameters automatically adjust for short input sequences and the expect threshold is 1000; 5) The match and mismatch scores are 1 and -3, respectively; 6) The penalty to create and extend a gap in an alignment is 5 and 2 respectively.

2019-nCoV_N1 Assay:

Probe sequence of 2019-nCoV rRT-PCR assay N1 showed high sequence homology with SARS coronavirus and Bat SARS-like coronavirus genome. However, forward and reverse primers showed no sequence homology with SARS coronavirus and Bat SARS-like coronavirus genome. Combining primers and probe, there is no significant homologies with human genome, other coronaviruses or human microflora that would predict potential false positive rRT-PCR results.

2019-nCoV_N2 Assay:

The forward primer sequence of 2019-nCoV rRT-PCR assay N2 showed high sequence homology to Bat SARS-like coronaviruses. The reverse primer and probe sequences showed no significant homology with human genome, other coronaviruses or human microflora. Combining primers and probe, there is no prediction of potential false positive rRT-PCR results.

In summary, the 2019-nCoV rRT-PCR assay N1 and N2, designed for the specific detection of 2019-nCoV, showed no significant combined homologies with human genome, other coronaviruses, or human microflora that would predict potential false positive rRT-PCR results.

In addition to the *in silico* analysis, several organisms were extracted and tested with the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel to demonstrate analytical specificity and exclusivity. Studies were performed with nucleic acids extracted using the QIAGEN EZ1 Advanced XL instrument and EZ1 DSP Virus Kit. Nucleic acids were extracted from high titer preparations (typically $\geq 10^5$ PFU/mL or $\geq 10^6$ CFU/mL). Testing was performed using the ThermoFisher Scientific TaqPath™ 1-Step RT-qPCR Master Mix, CG on the Applied Biosystems™ 7500 Fast Dx Real-Time PCR instrument. The data demonstrate that the expected results are obtained for each organism when tested with the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel.

Table 8. Specificity/Exclusivity of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel

Virus	Strain	Source	2019-nCoV_N1	2019-nCoV_N2	Final Result
Human coronavirus	229E	Isolate	0/3	0/3	Neg.
Human coronavirus	OC43	Isolate	0/3	0/3	Neg.
Human coronavirus	NL63	clinical specimen	0/3	0/3	Neg.
Human coronavirus	HKU1	clinical specimen	0/3	0/3	Neg.
MERS-coronavirus		Isolate	0/3	0/3	Neg.
SARS-coronavirus		Isolate	0/3	0/3	Neg.
bocavirus	-	clinical specimen	0/3	0/3	Neg.
<i>Mycoplasma pneumoniae</i>		Isolate	0/3	0/3	Neg.
<i>Streptococcus</i>		Isolate	0/3	0/3	Neg.
Influenza A(H1N1)		Isolate	0/3	0/3	Neg.
Influenza A(H3N2)		Isolate	0/3	0/3	Neg.
Influenza B		Isolate	0/3	0/3	Neg.
Human adenovirus, type 1	Ad71	Isolate	0/3	0/3	Neg.
Human metapneumovirus	-	Isolate	0/3	0/3	Neg.
respiratory syncytial virus	Long A	Isolate	0/3	0/3	Neg.
rhinovirus		Isolate	0/3	0/3	Neg.
parainfluenza 1	C35	Isolate	0/3	0/3	Neg.
parainfluenza 2	Greer	Isolate	0/3	0/3	Neg.
parainfluenza 3	C-43	Isolate	0/3	0/3	Neg.
parainfluenza 4	M-25	Isolate	0/3	0/3	Neg.

Endogenous Interference Substances Studies:

The CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel uses conventional well-established nucleic acid extraction methods and based on our experience with CDC's other EUA assays, including the CDC Novel Coronavirus 2012 Real-time RT-PCR Assay for the presumptive detection of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and the CDC Human Influenza Virus Real-Time RT-PCR Diagnostic Panel-Influenza A/H7 (Eurasian Lineage) Assay for the presumptive detection of novel influenza A (H7N9) virus that are both intended for use with a number of respiratory specimens, we do not anticipate interference from common endogenous substances.

Specimen Stability and Fresh-frozen Testing:

To increase the likelihood of detecting infection, CDC recommends collection of lower respiratory and upper respiratory specimens for testing. If possible, additional specimen types (e.g., stool, urine) should be collected and should be stored initially until decision is made by CDC whether additional specimen sources should be tested. Specimens should be collected as soon as possible once a PUI is identified regardless of symptom onset. Maintain proper infection control when collecting specimens. Store specimens at 2-8°C and ship overnight to CDC on ice pack. Label each specimen container with the patient's ID number (e.g., medical record number), unique specimen ID (e.g., laboratory requisition number), specimen type (e.g., nasal swabs) and the date the sample was collected. Complete a CDC Form 50.34 for each specimen submitted.

Clinical Performance:

As of February 22, 2020, CDC has tested 2071 respiratory specimens from persons under investigation (PUI) in the U.S. using the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel. Specimen types include bronchial fluid/wash, buccal swab, nasal wash/aspirate, nasopharyngeal swab, nasopharyngeal/throat swab, oral swab, sputum, oropharyngeal (throat) swab, swab (unspecified), and throat swab.

Table 9: Summary of CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel Data Generated by Testing Human Respiratory Specimens Collected from PUI Subjects in the U.S.

Specimen Type	2019 nCoV Negative	2019 nCoV Positive	Inconclusive	Invalid	Total
Bronchial fluid/wash	2	0	0	0	2
Buccal swab	5	1	0	0	6
Nasal wash/aspirate	6	0	0	0	6
Nasopharyngeal swab	927	23	0	0	950
Nasopharyngeal swab/throat swab	4	0	0	0	4
Oral swab	476	9	0	0	485
Pharyngeal (throat) swab	363	10	0	1	374
Sputum	165	5	0	0	170
Swab (unspecified) ¹	71	1	0	0	72
Tissue (lung)	2	0	0	0	2
Total	2021	49	0	1	2071

¹Actual swab type information was missing from these upper respiratory tract specimens.

Two thousand twenty-one (2021) respiratory specimens of the 2071 respiratory specimens tested negative by the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel. Forty-nine (49) of the 2071 respiratory specimens tested positive by the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel. Only one specimen (oropharyngeal (throat) swab) was invalid. Of the 49 respiratory specimens that tested positive by the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel, seventeen (17) were confirmed by genetic sequencing and/or virus culture (positive percent agreement = 17/17, 95% CI: 81.6%-100%)

During the early phase of the testing, a total of 117 respiratory specimens collected from 46 PUI subjects were also tested with two analytically validated real-time RT-PCR assays that target separate and independent regions of the nucleocapsid protein gene of the 2019-nCoV, N4 and N5 assays. The nucleocapsid protein gene targets for the N4 and N5 assays are different and independent from the nucleocapsid protein gene targets for the two RT-PCR assays included in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel, N1 and N2. Any positive result from the N4 and/or the N5 assay was further investigated by genetic sequencing.

Performance of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel testing these 117 respiratory specimens was estimated against a composite comparator. A specimen was considered comparator negative if both the N4 and the N5 assays were negative. A specimen was considered comparator positive when the N4 and/or the N5 assay generated a positive result, and the comparator positive result(s) were further investigated and confirmed to be 2019-nCoV RNA positive by genetic sequencing.

Table 10: Percent Agreement of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel with the Composite Comparator

CDC 2019-nCoV Panel Result	Composite Comparator Result	
	Positive	Negative
Positive	13 ¹	0
Inconclusive	0	0
Negative	0	104

¹Composite comparator results were available for 13 of 49 CDC 2019-nCoV Panel positive specimens only.

Positive percent agreement = $13/13 = 100\%$ (95% CI: 77.2% - 100%)

Negative percent agreement = $104/104 = 100\%$ (95% CI: 96.4% - 100%)

Enzyme Master Mix Evaluation:

The limit of detection equivalence between the ThermoFisher TaqPath™ 1-Step RT-qPCR Master Mix and the following enzyme master mixes was evaluated: Quantabio qScript XLT One-Step RT-qPCR ToughMix, Quantabio UltraPlex 1-Step ToughMix (4X), and Promega GoTaq® Probe 1- Step RT-qPCR System. Serial dilutions of 2019 novel coronavirus (SARS CoV-2) transcript were tested in triplicate with the CDC 2019-nCoV Real-time RT-PCR Diagnostic Panel using all four enzyme master mixes. Both manufactured versions of oligonucleotide probe, BHQ and ZEN, were used in the comparison. The lowest detectable concentration of transcript at which all replicates tested positive using the Quantabio qScript XLT One-Step RT-qPCR ToughMix and Quantabio UltraPlex 1-Step ToughMix (4X) was similar to that observed for the ThermoFisher TaqPath™ 1-Step RT-qPCR Master Mix. The lowest detectable concentration of transcript when using the Promega GoTaq® Probe 1- Step RT-qPCR System was one dilution above that observed for the other candidates when evaluated with the BHQ version of the CDC assays. The candidate master mixes all performed equivalently or at one dilution below the ThermoFisher TaqPath™ 1-Step RT-qPCR Master Mix when evaluated with the ZEN version of the CDC assays.

Table 11: Limit of Detection Comparison for Enzyme Master Mixes – BHQ Probe Summary Results

Copy Number	ThermoFisher TaqPath™ 1-Step RT-qPCR Master Mix		Quantabio qScript XLT One-Step RT-qPCR ToughMix		Quantabio UltraPlex 1- Step ToughMix (4X)		Promega GoTaq® Probe 1- Step RT-qPCR System	
	2019- nCoV_N1	2019- nCoV_N2	2019- nCoV_N1	2019- nCoV_N2	2019- nCoV_N1	2019- nCoV_N2	2019- nCoV_N1	2019- nCoV_N2
10 ² copies/μL	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3
10 ¹ copies/μL	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3
10 ⁰ copies/μL	3/3	3/3	3/3	3/3	3/3	3/3	3/3	2/3
10 ⁻¹ copies μL	2/3	0/3	1/3	1/3	1/3	1/3	0/3	0/3

Table 12: Limit of Detection Comparison for Enzyme Master Mixes – ZEN Probe Summary Results

Copy Number	ThermoFisher TaqPath™ 1-Step RT-qPCR Master Mix		Quantabio qScript XLT One-Step RT-qPCR ToughMix		Quantabio UltraPlex 1- Step ToughMix (4X)		Promega GoTaq® Probe 1- Step RT-qPCR System	
	2019- nCoV_N1	2019- nCoV_N2	2019- nCoV_N1	2019- nCoV_N2	2019- nCoV_N1	2019- nCoV_N2	2019- nCoV_N1	2019- nCoV_N2
10 ² copies/μL	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3
10 ¹ copies/μL	3/3	3/3	3/3	3/3	3/3	3/3	3/3	3/3
10 ⁰ copies/μL	3/3	2/3	3/3	3/3	3/3	2/3	3/3	3/3
10 ⁻¹ copies μL	1/3	1/3	0/3	0/3	0/3	1/3	1/3	1/3

Retrospective positive (18) and negative (17) clinical respiratory specimens were extracted using the QIAGEN EZ1 Advanced XL instrument and EZ1 DSP Virus Kit and were tested with the CDC 2019-nCoV Real-time RT-PCR Diagnostic Panel using the Quantabio qScript XLT One-Step RT-qPCR ToughMix, Quantabio UltraPlex 1-Step ToughMix (4X), and Promega GoTaq® Probe 1- Step RT-qPCR System master mixes. All three enzyme master mixes performed equivalently, demonstrating 100% positive and 100% negative agreement with expected results and a 95% confidence interval of 82.4%-100% and 81.6%-100%, respectively.

Table 13: Clinical Comparison – Retrospective Study Summary Results

CDC 2019-nCoV Real-time RT-PCR Diagnostic Panel Result	Quantabio qScript XLT One-Step RT-qPCR ToughMix		Quantabio UltraPlex 1-Step ToughMix (4X)		Promega GoTaq® Probe 1- Step RT-qPCR System	
	Positive	Negative	Positive	Negative	Positive	Negative
Positive	18	0	18	0	18	0
Negative	0	17	0	17	0	17

Roche MagNA Pure 24 and MagNA Pure 96 Extraction Platform Evaluation:

Performance of the 2019-CoV Real-time RT-PCR Diagnostic Panel using the Roche MagNA Pure 24 and MagNA Pure 96 extraction platforms was compared to performance with an authorized extraction method. Serial dilutions of quantified inactivated SARS-CoV-2 virus (USA-WA1/2020; 100 RNA copies/ μ L) in lysis buffer were added to pooled negative upper respiratory tract specimen matrix. Five samples of each dilution were extracted in parallel with the QIAGEN EZ1 Advanced XL (EZ1 DSP Virus Kit Cat# 62724) and the Roche MagNA Pure 24 (MagNA Pure 24 Total NA Isolation Kit Cat# 07658036001) and Roche MagNA Pure 96 (MagNA Pure 96 DNA and Viral Nucleic Acid Small Volume Kit Cat# 06543588001) extraction platforms and evaluated using the 2019-nCoV Real-Time RT-PCR Diagnostic Panel and ThermoFisher TaqPath™ 1-Step RT-qPCR Master Mix. The observed LoD was defined as the lowest concentration at which 100% (5 out of 5 total) of all replicates tested positive for both primer/probe sets (N1 and N2) in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel. The acceptance criteria for equivalence were defined as demonstrating an observed LoD either at the same endpoint or within a 3-fold dilution. The results showed that both the MagNA Pure 24 and MagNA Pure 96 extraction platforms performed equivalently or within one 3-fold dilution of the LoD observed when using the QIAGEN EZ1 Advanced XL extraction platform.

Table 14. Limit of Detection Comparison between the QIAGEN EZ1 Advanced XL, Roche MagNA Pure 96, and Roche MagNA Pure 24 Extraction Platforms using the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel

Platform	Parameter	2019-nCoV_N1 Assay			2019-nCoV_N2 Assay			Observed LoD ¹
QIAGEN EZ1 Advanced XL	RNA copies/ μ L	10 ^{1.0}	10 ^{0.5}	10 ^{0.0}	10 ^{1.0}	10 ^{0.5}	10 ^{0.0}	10 ^{0.5}
	# pos./total	5/5	5/5	5/5	5/5	5/5	3/5	
	Mean Ct ²	34.0	35.0	36.3	33.9	36.6	NA	
	Std. Deviation	0.2	0.8	0.2	0.4	0.9	NA	
Roche MagNA Pure 96	RNA copies/ μ L	10 ^{1.0}	10 ^{0.5}	10 ^{0.0}	10 ^{1.0}	10 ^{0.5}	10 ^{0.0}	10 ^{0.5}
	# pos./total	5/5	5/5	5/5	5/5	5/5	2/5	
	Mean Ct ²	33.3	34.6	36.1	33.2	35.7	NA	
	Std. Deviation	0.5	0.5	0.3	0.3	0.4	NA	
Roche MagNA Pure 24	RNA copies/ μ L	10 ^{1.0}	10 ^{0.5}	10 ^{0.0}	10 ^{1.0}	10 ^{0.5}	10 ^{0.0}	10 ^{1.0}
	# pos./total	5/5	3/5	3/5	5/5	5/5	5/5	
	Mean Ct ²	34.4	NA	NA	35.2	36.9	36.2	
	Std. Deviation	0.6	NA	NA	0.5	1.0	0.8	

¹Concentration is presented in RNA copies/ μ L. The observed LoD is the lowest concentration where both assays showed 100% positive detection.

²Mean Ct reported for dilutions that show 100% positivity. Calculations only include positive results.

NA = not applicable

Previously characterized clinical remainder specimens (14 positive and 15 negative) were extracted using both the Roche MagNA Pure 96 and MagNA Pure 24 extraction platforms and evaluated using the 2019-nCoV Real-Time RT-PCR Diagnostic Panel and ThermoFisher TaqPath™ 1-Step RT-qPCR Master Mix. Acceptance criteria for clinical equivalence was defined as demonstrating 100% concurrence with qualitative results shown with the authorized comparator method (QIAGEN EZ1 Advanced XL). Results from this study showed 100% concurrence with the comparator method for both the Roche MagNA Pure

96 and Roche MagNA Pure 24 extraction platforms when used with the CDC 2019-nCoV Real-Time RT-PCR Diagnostic panel.

Table 15. Clinical Comparison Results – Retrospective Study Results

Test Platform	Test Platform Result	QIAGEN EZ1 Advanced XL Result		Positive % Agreement (CI) ¹	Negative % Agreement (CI) ¹
		Positive	Negative		
Roche MagNA Pure 96	Positive	14	0	100.0 (78.5 – 100.0)	100.0 (79.6 – 100.0)
	Negative	0	15		
Roche MagNA Pure 24	Positive	14	0	100.0 (78.5 – 100.0)	100.0 (79.6 – 100.0)
	Negative	0	15		

¹ CI = 95% confidence interval

Promega Maxwell® RSC 48 Extraction Platform Evaluation:

Performance of the 2019-CoV Real-time RT-PCR Diagnostic Panel using the Promega Maxwell® RSC 48 extraction platform was compared to performance with an authorized extraction method. Serial dilutions of quantified inactivated SARS-CoV-2 virus (USA-WA1/2020; 100 RNA copies/μL) in VTM were added to pooled negative upper respiratory tract specimen matrix. Five samples of each dilution were extracted in parallel with the QIAGEN EZ1® Advanced XL (EZ1 DSP Virus Kit Cat# 62724) and the Promega Maxwell® RSC 48 (Promega Maxwell® Viral Total Nucleic Acid Purification Kit Cat# AS1330) extraction platforms and evaluated using the 2019-nCoV Real-Time RT-PCR Diagnostic Panel and ThermoFisher TaqPath™ 1-Step RT-qPCR Master Mix. The observed LoD was defined as the lowest concentration at which 100% (5 out of 5 total) of all replicates tested positive for both primer/probe sets (N1 and N2) in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel. The acceptance criteria for equivalence were defined as demonstrating an observed LoD either at the same endpoint or within a 3-fold dilution. The results showed that the performance of the Maxwell® RSC 48 extraction platform performed equivalently or within one 3-fold dilution of the LoD observed when using the QIAGEN EZ1® Advanced XL extraction platform.

Table 16. Limit of Detection Comparison Between the QIAGEN EZ1® Advanced XL and Promega Maxwell® RSC 48 Extraction Platforms Using the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel

Platform	Parameter	2019-nCoV_N1 Assay			2019-nCoV_N2 Assay			Observed LoD ¹
QIAGEN EZ1® Advanced XL	RNA copies/μL	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}	10 ^{0.0}
	# pos./total	5/5	5/5	0/5	5/5	5/5	3/5	
	Mean Ct ²	32.27	33.80	NA	35.13	36.41	NA	
	Std. Deviation	0.81	0.40	NA	0.81	0.40	NA	
Promega Maxwell® RSC 48	RNA copies/μL	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}	10 ^{0.0}
	# pos./total	5/5	5/5	3/5	5/5	5/5	5/5	
	Mean Ct ²	31.11	32.97	NA	31.89	33.95	35.17	
	Std. Deviation	0.24	0.34	NA	0.24	0.35	0.65	

¹Concentration is presented in RNA copies/μL. The observed LoD is the lowest concentration where both assays showed 100% positive detection.

²Mean cycle threshold (Ct) reported for dilutions that show 100% positivity. Calculations only include positive results. NA = not applicable

Previously characterized clinical remainder specimens (15 positive and 15 negative) were extracted using the Promega Maxwell® RSC 48 extraction platform alongside the currently authorized QIAGEN EZ1® Advanced XL extraction platform and evaluated using the 2019-nCoV Real-Time RT-PCR Diagnostic Panel and ThermoFisher TaqPath™ 1-Step RT-qPCR Master Mix. Results from the Maxwell® RSC 48 were compared with the QIAGEN EZ1® Advanced XL extraction performed in parallel showing 100% (15/15) qualitative concurrence on positive samples and 93.3% (14/15) qualitative concurrence on negative samples. This evaluation showed that two originally negative (QIAGEN QIAamp® DSP Viral RNA Mini Kit) specimens (Specimens 16 and 24) yielded an inconclusive result after extraction using the QIAGEN EZ1® Advanced XL. Repeat of the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel resolved one of the two specimens (Specimen 24, negative result). The second specimen (Specimen 16) remained inconclusive. Both these specimens yielded a negative result on the Maxwell® RSC 48.

Table 17. Clinical Comparison Results – Retrospective Study Results

Test Platform	Result	Promega Maxwell® RSC 48			Positive % Agreement (CI) ¹	Negative % Agreement (CI) ¹
		Positive	Negative	Inconclusive		
QIAGEN EZ1® Advanced XL	Positive	15	0	0	100.0 (79.6-100.0)	93.3 (70.2-98.9)
	Negative	0	14	0		
	Inconclusive	0	1	0		

¹ CI = 95% confidence interval

Disposal

Dispose of hazardous or biologically contaminated materials according to the practices of your institution.

References

1. Ballew, H. C., *et al.* "Basic Laboratory Methods in Virology," DHHS, Public Health Service 1975 (Revised 1981), Centers for Disease Control and Prevention, Atlanta, Georgia 30333.
2. Clinical Laboratory Standards Institute (CLSI), "Collection, Transport, Preparation and Storage of Specimens for Molecular Methods: Proposed Guideline," MM13-A
3. Lieber, M., *et al.* "A Continuous Tumor Cell Line from a Human Lung Carcinoma with Properties of Type II Alveolar Epithelial Cells." *International Journal of Cancer* 1976, 17(1), 62-70.

Revision History

Revision #	Effective Date	Summary of Revisions
1	February 4, 2020	Original Instructions for Use
2	March 15, 2020	<ul style="list-style-type: none"> • Intended use update • Removal of N3 primer and probe set from Diagnostic Panel • Performance data update • Addition of alternative nucleic acid extraction platforms • Addition of acceptable alternatives to HSC and addition of QIAGEN RUO extraction reagents • Positive results no longer presumptive. No confirmation of positive results required
3	March 30, 2020	<ul style="list-style-type: none"> • Addition of alternative enzyme master mix options
4	June 12, 2020	<ul style="list-style-type: none"> • Addition of MagNA Pure 24 extraction method • Addition of performance data for the MagNA Pure 96 extraction method with SARS-CoV-2 • Addition of heat treatment alternative to specimen extraction • Addition of Roche and QIAGEN external lysis buffer alternatives • Acknowledgment of FDA policy permitting end users to qualify alternative components without seeking an EUA or EUA amendment
5	July 13, 2020	<ul style="list-style-type: none"> • Addition of Promega Maxwell® RSC 48 extraction method • Update to <i>in silico</i> inclusivity analyses

Contact Information, Ordering, and Product Support

For technical and product support, contact the CDC Division of Viral Diseases directly.

Send email to: respvirus@cdc.gov

Note: If your laboratory is using reagents sourced from someone other than the CDC International Reagent Resource, please refer to the manufacturer's instructions provided with the commercial materials.

Appendix A: Heat Treatment Alternative to Extraction **UltraPlex 1-Step ToughMix (4X)**

This procedure is only for use by public health laboratories.

Purpose:

In response to a global shortage of nucleic acid extraction reagents causing significant delays in testing, the CDC has investigated the use of a heat treatment method requiring minimal reagents as a specimen processing alternative to nucleic acid extraction for use with the 2019-nCoV Real-Time RT-PCR Diagnostic Panel.

Where possible, laboratories should use qualified RNA or total nucleic acid extraction methods for processing of specimens for subsequent testing by the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel. Extraction removes inhibitory substances from specimens that could negatively impact PCR performance.

This procedure for use of heat treatment for specimen processing is only recommended when a shortage of qualified extraction reagents is a limiting factor in a laboratory's ability to meet urgent COVID-19 testing demand.

Precautions/Warnings/Limitations:

- CDC has evaluated this heat treatment process and has determined that this process is effective for inactivation of SARS-CoV-2 in patient specimens.
- Performance was evaluated with only upper respiratory specimens. Heat treatment of lower respiratory specimens for subsequent testing by the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel has not been evaluated.
- This procedure for heat treatment of specimens is only for use with the Quantabio UltraPlex 1-Step ToughMix (4X).
- Heat treatment should only be conducted when a lab is ready to test the specimens by PCR. Testing of heat-treated specimens must be conducted the same day.

Acceptable Specimens:

- Upper respiratory specimens
 Note: Do not use heat treatment to process specimens that appear bloody or that contain particulate matter. Such specimens should be extracted using a qualified RNA or TNA extraction method prior to testing.

Materials Required (not provided):

- 70% ethanol
- 10% bleach, freshly prepared
- 96-well PCR reaction plates (Applied Biosystems catalog # 4346906, 4366932, 4346907, or equivalent)
- Optical strip caps (Applied Biosystems 4323032, or equivalent)
- 1.5 mL Sarstedt tubes or equivalent

- Aerosol resistant micropipette tips
- Micropipettes
- 96-well cold block
- Cold blocks for 1.5 mL - 2.0 mL tubes
- Vortex mixer
- 96-well plate centrifuge or equivalent
- Thermal cycler or equivalent
- Class II Biological Safety Cabinet (BSC)

Procedure:

Sample Preparation

- 1) Decontaminate BSC with 10% bleach followed by 70% ethanol.
- 2) If samples are frozen, thaw on ice or at 4°C. Wipe the outside of the sample tube with 70% ethanol. Place thawed sample on cold rack or ice in BSC.
- 3) Pulse vortex each sample and briefly spin down in a centrifuge to collect the liquid at the bottom of the tube.

Heat Treatment

- 1) Place a thermal cycler in the BSC, turn on, and program for 95°C for 1 min followed by 4°C hold.
- 2) Place a 96-well PCR plate onto a cold rack or ice in the BSC.
- 3) Transfer 100 µL of each sample to the 96-well PCR plate and securely cap each well using optical strip caps.
NOTE: Ensure that an HSC extraction control is included in each batch run as required under CLIA.
- 4) Place this 96-well PCR plate on the pre-heated thermal cycler and start run. Leave plate on thermal cycler at 4°C, or place on ice or a cold block.
- 5) Remove plate and centrifuge for 1 minute at 500 x g to pellet cellular debris.
- 6) Place plate on a cold rack or ice and proceed to testing the supernatant by rRT-PCR.
- 7) Testing of heat-treated specimens must be conducted the same day heat treatment is performed. For long term storage, keep the original specimen at ≤-70°C.

Special Testing Considerations for Heat Treated Specimens:

- **Enzyme Master Mix**

Testing of specimens that have been processed with heat treatment should be conducted with the **Quantabio UltraPlex 1-Step ToughMix (4X)**, which demonstrated the best performance with heat treated specimens. PCR testing of heat-treated specimens should follow the instructions in the main body of this Instructions for Use document.

- **Resolution of Inconclusive and Invalid Results**

Retesting of heat-treated specimens that generated an inconclusive or invalid result must include extraction of the original specimen with a qualified RNA or total nucleic acid (TNA) extraction method, if available. Do not re-test the heat-treated specimen material to resolve inconclusive or invalid test results.

Verification:

CDC recommends performance of verification studies for the heat treatment method prior to diagnostic use that includes side-by-side preparation of a panel of positive and negative clinical specimens using a qualified extraction method and this heat treatment method with subsequent testing by the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel.

Performance Characteristics:*Quantabio UltraPlex 1-Step ToughMix (4X)**Limit of Detection Comparison*

Serial dilutions of inactivated SARS-CoV-2 [SARS-CoV-2 USA-WA1/2020] were prepared in simulated specimen material (human A549 cells suspended in viral transport medium). Each concentration was prepared side-by-side five times by both EZ1 extraction and by heat treatment. Each extracted or heat-treated sample was subsequently tested by the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel using the Quantabio UltraPlex 1-Step ToughMix (4X) on the Applied Biosystems 7500 Fast Dx instrument. Observed detection was similar between the two specimen preparation methods.

Table B1: UltraPlex Limit of Detection Comparison between QIAGEN EZ1 Advanced XL extraction and heat treatment (95°C for 1 min) method – Summary Results

Enzyme	Platform	Parameter	2019-nCoV_N1 Assay					2019-nCoV_N2 Assay					Observed LoD ¹
Quantabio UltraPlex 1-Step ToughMix (4X) 5 µL Template Addition	QIAGEN EZ1 Advanced XL	RNA copies/µL	10 ^{1.0}	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}	10 ^{-1.0}	10 ^{1.0}	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}	10 ^{-1.0}	10 ^{0.5}
		# pos./total	5/5	5/5	4/5	4/5	3/5	5/5	5/5	5/5	2/5	2/5	
		Mean Ct ²	34.11	34.59	NA	NA	NA	32.97	33.76	34.70	NA	NA	
		Std. Deviation	0.75	0.99	NA	NA	NA	0.33	0.72	0.98	NA	NA	
	Heat Treatment 95°C for 1 min	RNA copies/µL	10 ^{1.0}	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}	10 ^{-1.0}	10 ^{1.0}	10 ^{0.5}	10 ^{0.0}	10 ^{-0.5}	10 ^{-1.0}	10 ^{0.5}
		# pos./total	5/5	5/5	4/5	5/5	1/5	5/5	5/5	4/5	2/5	1/5	
		Mean Ct ²	33.41	34.32	NA	36.73	NA	33.45	35.25	NA	NA	NA	
		Std. Deviation	0.62	0.40	NA	0.82	NA	0.40	0.80	NA	NA	NA	

¹Concentration is presented in RNA copies/µL. The observed LoD is the lowest concentration where both assays showed 100% positive detection.

²Mean Ct reported for dilutions that show 100% positivity. Calculations only include positive results.

NA = not applicable

Clinical Comparison

A panel of 39 upper respiratory specimens were tested side-by-side using extraction with the Qiagen EZ1 extraction instrument and heat treatment. Extracted and heat-treated specimens were subsequently tested with the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel using the Quantabio UltraPlex 1-Step ToughMix (4X). Qualitative results were compared to demonstrate agreement.

Table B2: Clinical Comparison Results Summary – Heat Treatment versus QIAGEN EZ1 Advanced XL

	Test Result	Heat Treatment			Total	Positive % Agreement (CI) ¹	Negative % Agreement (CI) ¹
		Positive	Inconclusive	Negative			
QIAGEN EZ1 Advanced XL	Positive	18	1	0	19	94.7 (75.4-99.1)	100 (83.9-100)
	Inconclusive	0	0	0	0		
	Negative	0	0	20	20		
	Total	18	1	20	39		

¹ CI = 95% confidence interval

Questions and Comments:

If you have questions or comments about this procedure, please send by email to: respvirus@cdc.gov

CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel – Verification Requirements

***** DO NOT DISCARD: Important product-specific information *****

CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel – Verification Requirements

Please consult the following guidance from the Centers for Medicare & Medicaid Services (CMS) regarding diagnostic tests under Emergency Use Authorization (EUA):

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/QSO18-19-CLIA>

INTENDED USE

The CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel is a real-time RT-PCR test intended for the qualitative detection of nucleic acid from the 2019-nCoV in upper and lower respiratory specimens (such as nasopharyngeal or oropharyngeal swabs, sputum, lower respiratory tract aspirates, bronchoalveolar lavage, and nasopharyngeal wash/aspirate or nasal aspirate) collected from individuals who meet 2019-nCoV clinical and/or epidemiological criteria (for example, clinical signs and symptoms associated with 2019-nCoV infection, contact with a probable or confirmed 2019-nCoV case, history of travel to a geographic locations where 2019-nCoV cases were detected, or other epidemiologic links for which 2019-nCoV testing may be indicated as part of a public health investigation). Testing in the United States is limited to laboratories certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 U.S.C. § 263a, to perform high complexity tests.

Results are for the identification of 2019-nCoV RNA. The 2019-nCoV RNA is generally detectable in upper and lower respiratory specimens during infection. Positive results are indicative of active infection with 2019-nCoV but do not rule out bacterial infection or co-infection with other viruses. The agent detected may not be the definite cause of disease. Laboratories within the United States and its territories are required to report all positive results to the appropriate public health authorities.

Negative results do not preclude 2019-nCoV infection and should not be used as the sole basis for treatment or other patient management decisions. Negative results must be combined with clinical observations, patient history, and epidemiological information.

Testing with the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel is intended for use by trained laboratory personnel who are proficient in performing real-time RT-PCR assays. The CDC 2019-Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel is only for use under a Food and Drug Administration's Emergency Use Authorization.

REQUIRED MATERIALS

The 2019 novel coronavirus positive control (nCoVPC) is provided with the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel and should be prepared according to the Instructions for Use. The nCoVPC consists of an RNA transcript of the 2019-nCoV N gene as well as human RNase P gene segment. nCoVPC will yield a positive result with the following primer and probe sets: 2019-nCoV_N1, 2019-nCoV_N2, and RP.

Approximately 2 mL of an upper respiratory specimen (e.g. nasopharyngeal swab (NPS) in transport media) are needed for testing. Specimens may be pooled if less than 2 mL of one specimen is available.

Refer to CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel package insert (manufacturer instructions) for additional reagents, materials, and instructions.

PRECAUTIONS

This reagent should be handled in an approved biosafety level 2 (BSL-2) handling area to avoid contamination of laboratory equipment and reagents that could cause false positive

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results. This product is an RNA transcript and is non-infectious. However, the nCoVPC should be handled in accordance with Good Laboratory Practices.

Store reagent at appropriate temperatures (see Instructions for Use) and hold on ice when thawed.

Please use standard precautions when handling respiratory specimens.

INSTRUCTIONS FOR PREPARING SAMPLES BEFORE EXTRACTION WITH THE QIAamp® DSP VIRAL RNA MINI KIT OR THE QIAamp® VIRAL RNA MINI KIT

- Refer to the 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use for reconstitution of the materials for use. RNA should be kept cold during preparation and use.
- Make a 1/10 dilution of nCoVPC by adding 5 µL of nCoVPC into 45 µL of nuclease-free water or 10 mM Tris.
- Aliquot 560 µL of lysis buffer into each of nine tubes labeled 1-9.
- Add 140 µL of upper respiratory specimen (e.g. NPS in viral transport media) into each of the nine labeled tubes with lysis buffer.
- To prepare samples at a moderate concentration, spike 14 µL of undiluted nCoVPC (rehydrated as described in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use) into each tube labeled 1-3 containing lysis buffer and specimen.
- To prepare samples at a low concentration, spike 14 µL of 1/10 dilution of nCoVPC into each tube labeled 4-6 containing lysis buffer and specimen.
- To prepare negative samples, spike 14 µL of nuclease-free water into each tube labeled 7-9 containing lysis buffer and specimen.
- Perform extractions of all nine samples according to the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use.

INSTRUCTIONS FOR PREPARING SAMPLES BEFORE EXTRACTION WITH THE QIAGEN EZ1® ADVANCED XL

- Refer to the 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use for reconstitution of the materials for use. RNA should be kept cold during preparation and use.
- Make a 1/10 dilution of nCoVPC by adding 5 µL of nCoVPC into 45 µL of nuclease-free water or 10 mM Tris.
- Aliquot 280 µL of lysis buffer into each of nine tubes labeled 1-9.
- Add 120 µL of upper respiratory specimen (e.g. NPS in viral transport media) into each of the nine labeled tubes with lysis buffer.
- To prepare samples at a moderate concentration, spike 12 µL of undiluted nCoVPC (rehydrated as described in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use) into each tube labeled 1-3 containing lysis buffer and specimen.
- To prepare samples at a low concentration, spike 12 µL of 1/10 dilution of nCoVPC into each tube labeled 4-6 containing lysis buffer and specimen.
- To prepare negative samples, spike 12 µL of nuclease-free water into each tube labeled 7-9 containing lysis buffer and specimen.
- Perform extractions of all nine samples according to the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use.

INSTRUCTIONS FOR PREPARING SAMPLES BEFORE EXTRACTION WITH THE ROCHE MagNA PURE TOTAL NUCLEIC ACID KIT OR THE ROCHE MagNA PURE NUCLEIC ACID ISOLATION KIT I

- Refer to the 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use for reconstitution of the materials for use. RNA should be kept cold during preparation and use.
- Make a 1/10 dilution of nCoVPC by adding 5 µL of nCoVPC into 45 µL of nuclease-free water or 10 mM Tris.
- Aliquot 300 µL of lysis buffer into each of nine tubes labeled 1-9.
- Add 100 µL of upper respiratory specimen (e.g. NPS in viral transport media) into each of the nine labeled tubes with lysis buffer.

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- To prepare samples at a moderate concentration, spike 12 µL of undiluted nCoVPC (rehydrated as described in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use) into each tube labeled 1-3 containing lysis buffer and specimen.
- To prepare samples at a low concentration, spike 12 µL of 1/10 dilution of nCoVPC into each tube labeled 4-6 containing lysis buffer and specimen.
- To prepare negative samples, spike 12 µL of nuclease-free water into each tube labeled 7-9 containing lysis buffer and specimen.
- Perform extractions of all nine samples according to the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use.

INSTRUCTIONS FOR PREPARING SAMPLES BEFORE EXTRACTION WITH THE ROCHE MagNA PURE 24 AND TOTAL NUCLEIC ACID ISOLATION KIT

- Refer to the 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use for reconstitution of the materials for use. RNA should be kept cold during preparation and use.
- Make a 1/10 dilution of nCoVPC by adding 5 µL of nCoVPC into 45 µL of nuclease-free water or 10 mM Tris.
- Aliquot 400 µL of lysis buffer into each of nine tubes labeled 1-9.
- Add 100 µL of upper respiratory specimen (e.g. NPS in viral transport media) into each of the nine labeled tubes with lysis buffer.
- To prepare samples at a moderate concentration, spike 12 µL of undiluted nCoVPC (rehydrated as described in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use) into each tube labeled 1-3 containing lysis buffer and specimen.
- To prepare samples at a low concentration, spike 12 µL of 1/10 dilution of nCoVPC into each tube labeled 4-6 containing lysis buffer and specimen.
- To prepare negative samples, spike 12 µL of nuclease-free water into each tube labeled 7-9 containing lysis buffer and specimen.
- Perform extractions of all nine samples according to the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use.

INSTRUCTIONS FOR PREPARING SAMPLES BEFORE EXTRACTION WITH THE ROCHE MagNA PURE 96 DNA AND VIRAL NA SMALL VOLUME KIT

- Refer to the 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use for reconstitution of the materials for use. RNA should be kept cold during preparation and use.
- Make a 1/10 dilution of nCoVPC by adding 5 µL of nCoVPC into 45 µL of nuclease-free water or 10 mM Tris.
- Aliquot 350 µL of lysis buffer into each of nine tubes labeled 1-9.
- Add 100 µL of upper respiratory specimen (e.g. NPS in viral transport media) into each of the nine labeled tubes with lysis buffer.
- To prepare samples at a moderate concentration, spike 12 µL of undiluted nCoVPC (rehydrated as described in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use) into each tube labeled 1-3 containing lysis buffer and specimen.
- To prepare samples at a low concentration, spike 12 µL of 1/10 dilution of nCoVPC into each tube labeled 4-6 containing lysis buffer and specimen.
- To prepare negative samples, spike 12 µL of nuclease-free water into each tube labeled 7-9 containing lysis buffer and specimen.
- Perform extractions of all nine samples according to the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use.

INSTRUCTIONS FOR PREPARING SAMPLES BEFORE EXTRACTION WITH THE PROMEGA MAXWELL® RSC 48

- Refer to the 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use for reconstitution of the materials for use. RNA should be kept cold during preparation and use.
- Make a 1/10 dilution of nCoVPC by adding 5 µL of nCoVPC into 45 µL of nuclease-free water or 10 mM Tris.
- Aliquot 330 µL of lysis buffer (300 µL of lysis buffer + 30 µL Proteinase K, included in the kit) into each of nine tubes labeled 1-9.

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- Add 120 µL of upper respiratory specimen (e.g. NPS in viral transport media) into each of the nine labeled tubes with lysis buffer.
- To prepare samples at a moderate concentration, spike 12 µL of undiluted nCoVPC (rehydrated as described in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use) into each tube labeled 1-3 containing lysis buffer and specimen.
- To prepare samples at a low concentration, spike 12 µL of 1/10 dilution of nCoVPC into each tube labeled 4-6 containing lysis buffer and specimen.
- To prepare negative samples, spike 12 µL of nuclease-free water into each tube labeled 7-9 containing lysis buffer and specimen.
- Perform extractions of all nine samples according to the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use.

INSTRUCTIONS FOR PREPARING SAMPLES BEFORE EXTRACTION WITH THE BIOMÉRIEUX NucliSENS easyMAG OR THE BIOMÉRIEUX EMAG

- Refer to the 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use for reconstitution of the materials for use. RNA should be kept cold during preparation and use.
- Make a 1/10 dilution of nCoVPC by adding 5 µL of nCoVPC into 45 µL of nuclease-free water or 10 mM Tris.
- Aliquot 1000 µL or 2000 µL of pre-aliquoted easyMAG lysis buffer into each of nine tubes labeled 1-9 for the easyMAG or eMAG, respectively.
- Add 100 µL of upper respiratory specimen (e.g. NPS in viral transport media) into each of the nine labeled tubes with lysis buffer.
- To prepare samples at a moderate concentration, spike 12 µL of undiluted nCoVPC (rehydrated as described in the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use) into each tube labeled 1-3 containing lysis buffer and specimen.
- To prepare samples at a low concentration, spike 12 µL of 1/10 dilution of nCoVPC into each tube labeled 4-6 containing lysis buffer and specimen.
- To prepare negative samples, spike 12 µL of nuclease-free water into each tube labeled 7-9 containing lysis buffer and specimen.
- Perform extractions of all nine samples according to the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use.

PROCEDURE

Follow the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel Instructions for Use for testing the nine extracted samples at least once.

EXPECTED RESULTS

Moderate nCoVPC samples should be positive for 2019-nCoV.

Low nCoVPC samples should be positive for 2019-nCoV.

Negative upper respiratory samples should be negative for 2019-nCoV.

≥90% of test results should be in agreement with the expected results. If test results are <90% in agreement with expected results, contact CDC at respvirus@cdc.gov.

QUESTIONS

Please send questions or comments by email to respvirus@cdc.gov.

DISTRIBUTION

Distributed to qualified laboratories by Centers for Disease Control and Prevention, 1600 Clifton Road, Atlanta, GA, 30329 USA